

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 06/14/2011	
NAME OF PROVIDER OR SUPPLIER ST JOHNS HOME FOR THE AGED				STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for the recertification and state licensure survey. This visit resulted in an extended survey-immediate jeopardy.</p> <p>Survey dates: June 6, 7, 8, 9, 10, 11, 12, 13, 14, 2011</p> <p>Facility number: 000443 Provider number: 15E359 Aim number: 100289580</p> <p>Survey team: Amy Wininger, RN TC Diane Hancock, RN</p> <p>Census bed type: NF: 42 Total: 42</p> <p>Census payor type: Medicaid: 41 Other: 1 Total: 42</p> <p>Sample: 11 Supplemental sample: 29</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0241 SS=D	<p>Quality review completed 6/19/11 Cathy Emswiler RN</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure 1 of 10 current sampled residents, in the total sample of 11, was cared for in a manner to maintain her dignity, in that CNAs washed the resident with paper towels instead of obtaining wash cloths. (Resident #12)</p> <p>Finding includes:</p> <p>On 6/8/11 at 5:20 p.m., CNA #1 and CNA #2 were observed taking Resident #12 to the restroom. The resident had been incontinent of a small amount of urine and a smear of bowel in the incontinence brief. The resident was cleaned, dried, and changed. When the resident was assisted to walk back to bed, she was incontinent of urine again in the clean brief. The CNAs assisted her to bed, removed the soiled brief, and obtained wet and soapy brown paper towels from the bathroom. They used the paper towels to wash, rinse, and then dry the resident's</p>			F0241	<p>Mandatory in-services were held for all nursing employees on June 14 and June 20, 2011, addressing peri-care procedures and review of preservation of dignity. CNAs will be monitored five times a week for one month as they provide peri-care. After the first month, twice a week CNAs will be randomly selected and observed. The CNAs will be monitored by the charge nurse, ADON and DON. All new employees will be in-serviced on peri-care during the orientation process, and ongoing bi-annual in-servicing will occur which will address peri-care and preservation of dignity. Ongoing monitoring for one year.</p>		06/30/2011

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	<p>perineal area. During interview at that time, CNA #1 stated, "No wash cloths, using what I have."</p> <p>On 6/8/11 at 6:50 p.m., the above was reviewed with the Director of Nurses. During interview at that time, she stated, "of course they should have gone and got wash cloths."</p> <p>The policy and procedure for Perineal Care, dated 7/2005, was provided by the Director of Nursing on 6/13/11 at 12:10 p.m. The procedure included, but was not limited to, the following: "Assemble supplies: a. Gloves, b. Wash cloth and towel, c. 'Peri wash' or soap and basin of water, d. Toilet tissue."</p> <p>3.1-3(t)</p>						

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F0279 SS=D	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to ensure care plans were developed and described specific services to be provided regarding activities and hydration, for 2 of 11 sampled residents in regards to activities (residents' #28, #9), and 1 of 3 sampled residents reviewed for hydration, in the sample of 11 (resident #41).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #28 was reviewed on 06/07/11 at 3:20 P.M.</p> <p>The most recent care plan, dated 03/22/11, lacked any documentation of an activity</p>			F0279	<p>All care plans have been reviewed with regard to hydration and the care plans have been updated with specific interventions. The care plans will be reviewed quarterly, or with change of condition, and updated as needed. All residents have been assessed for signs and symptoms of dehydration, and interventions initiated as needed. All residents will be assessed for signs and symptoms of dehydration and interventions initiated if indicated. Residents will be assessed weekly for signs and symptoms of dehydration and documented in the weekly summary. In-services for all nursing staff were held on June 23, June 24, June 27, and will be held on July 1, 2011, addressing</p>		07/14/2011

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	<p>care plan.</p> <p>2. The clinical record of Resident #9 was reviewed on 06/07/11 at 11:15 A.M.</p> <p>The most recent care plan, dated 05/16/11, lacked any documentation of an activity care plan.</p> <p>In an interview with the Activity Director [AD], on 06/10/11 at 10:30 A.M., she indicated, "There is no activity care plan for [name of Resident #9] or [name of Resident #28]."</p> <p>3. Resident #41's clinical record was reviewed on 6/6/11 at 2:35 p.m. The resident's diagnoses included, but was not limited to, chronic kidney disease, hypertension, and congestive heart failure. Medication orders, signed 5/19/11, included, but were not limited to, the following medication: Demadex [diuretic].</p> <p>Resident #41's only care plan regarding fluids was as follows: "[Resident's name] has the potential for</p>				<p>interventions to prevent dehydration. The MDS coordinator and DON will monitor the care plans and interventions. Ongoing monitoring for one year. Completed date: 07/08/11 The Activity Director was in-serviced on June 24, 2011 on care plans, problems, measurable goals, and specific interventions. Activity care plans on all residents have been developed according to resident's personal interest, level of cognition and physical and mental ability. The care plans have measurable goals and specific interventions. The care plans will be reviewed and updated quarterly or with change of condition. The MDS Coordinator will review activity care plans at each care plan review for specific goals and interventions. Ongoing monitoring for one year. Completed date: 07/14/11</p>		

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	<p>alteration in fluid maintenance: occasional edema, PO [by mouth] diuretic med use and diagnoses of CHF [congestive heart failure], pulmonary edema and renal insufficiency."</p> <p>The only interventions included the following: "-Give [Resident's name] Demadex 40 mg [milligrams] PO daily. Obtain labs per MD orders, provide prescribed diet (mech soft), monitor for signs and symptoms of fluid deficit/overload (tenting skin, edema, dry mouth, increase/decrease in urinary output etc.). -Give [resident's name] KCL [potassium chloride 10 meq [milliequivalents] PO daily."</p> <p>The care plan lacked specific planned interventions to provide the resident with adequate fluids to prevent dehydration.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>						

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F0280 SS=D	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care plans were reviewed and revised when fall prevention interventions were ineffective, for 3 of 7 sampled residents reviewed for falls, in the sample of 11. (residents' #28, #9, #30)</p> <p>Findings include:</p> <p>1. In an interview with the DoN [Director of Nursing] on 06/06/11 at 10:10 A.M., she indicated Resident #9 was not interviewable, and had fallen in the last two weeks.</p> <p>The clinical record of Resident #9 was reviewed on 06/07/11 at 11:15 A.M.</p>			F0280	<p>New fall assessments have been completed on all residents. After each fall, current interventions will be reviewed and new interventions initiated relating to the fall. If the fall prevention interventions are ineffective, new interventions will be initiated. An interdisciplinary falls committee will meet weekly to discuss residents that have fallen, current interventions, and new placed interventions. All care plans for falls have been reviewed and updated. The MDS / Care Plan Coordinator has been in-serviced addressing updating and revising of care plans with specific fall prevention interventions and revision of ineffective interventions. Mandatory in-services will be held on July 5, July 6, July 7, and July 8, 2011,</p>		07/11/2011

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	<p>The May 2011 Physician's Recap indicated Resident #9's diagnoses included, but were not limited to, chronic lower extremity pain.</p> <p>The most current MDS [Minimum Data Set Assessment], dated 04/14/11, indicated Resident #9 required extensive assist of one for transfer and had experienced two falls since the last assessment.</p> <p>The most recent care plan, updated 05/16/11, indicated a problem of, "...potential for falls: last document falls: 03/04/11 [line struck through] and a handwritten note indicated, 05/27/11. The care plan interventions were: "Ensure frequently used items are within [name of Resident #9] easy reach, encourage [name of Resident #9] ...ensure [name of Resident # 9] to request assist with transfer/ambulation as needed...ensure [name of Resident #9] has easy access to call light, ...ensure [name of Resident #9] is wearing appropriate, non-slip footwear, ensure [name of Resident#9] area is free of clutter, ...MD [Physician] to perform medication review and handwritten note dated 05/27/11 indicated, "CBC [Complete blood Count- lab test], CMP [Complete Metabolic Profile-a lab test]."</p> <p>The care plan intervention list lacked</p>				<p>for all nursing employees. The in-services will address tab and pad alarms correct usage. Residents with alarms in place will be checked each shift for correct placement of alarm and alarm box. Alarm assessments will be completed quarterly and as needed. Ongoing monitoring for one year. The charge nurse, ADON and DON will monitor.</p>		

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	<p>documentation of any updated interventions to prevent further falls.</p> <p>The Nurse's Notes, dated 12/10/10 at 8:45 P.M., indicated, "Summed [sic] to the room via a CNA [Certified Nursing Assistant]; found resident lying on a quilt parallel with lounge and head facing bathroom door..." The Nurse's Notes and care plan lacked any documentation of any updated interventions to prevent further falls.</p> <p>The Nurse's Notes, dated 12/17/10 at 5:15 P.M., indicated, "Another residents [sic] family member notified [name of staff member] that the resident was on the floor..." An additional Nurses's Note the same date at 8:00 P.M. indicated, "Found resident on the floor in the middle of the room on her right side...Grippy sock applied."</p> <p>In an interview with the DoN, on 06/07/11 at 2:00 P.M., she indicated the intervention of Grippy socks was not put on the care plan and should have been passed on verbally from shift to shift. The DoN further indicated there was no documentation to prove Grippy socks had been applied routinely since the fall.</p> <p>The Nurse's Notes, dated 01/08/11 at 7:00 P.M., indicated, "calling for help, found</p>						

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	<p>on floor by doorway entrance..." The Nurse's Notes lacked any documentation of any updated interventions to prevent further falls.</p> <p>The Nurse's Notes, dated 01/31/11 at 7:00 P.M., indicated, "Summoned to room per CNA Resident was on the floor in a supine position...resident stated she was getting ready for bed and sitting on the edge of the bed and slipped to the floor. Resident was barefooted. Gripper socks were applied before standing..."</p> <p>The Nurse's Notes, dated 03/04/11 at 6:50 P.M., indicated, "Heard yelling from her room. Resident on the floor in front of the toilet..." The Nurse's Notes and care plan lacked any updated interventions to prevent further falls.</p> <p>The Nurse's notes, dated 03/05/11 at 4:50 P.M., indicated, "...was on the floor with feet toward her bed sitting on the floor...said that she slid out of bed...she said she hit her head..." The nurse's notes lacked any updated interventions to prevent further falls.</p> <p>The Nurse's Notes, dated 05/13/11 at 4:00 P.M., indicated, "Resident found sitting on floor on buttock...resident said, "I just slid off the bed." The Nurse's notes and care plan lacked any updated</p>						

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	<p>interventions to prevent further falls.</p> <p>The Nurse's Notes, dated 05/27/11 at 3:40 P.M., indicated, "... Resident sitting on floor in front of recliner..."The Nurse's notes and care plan lacked any documentation of any updated interventions to prevent further falls.</p> <p>In an interview with the DoN on 06/07/11 at 1:00 P.M., she indicated she would not be able to provide documentation of specific interventions for each fall. She further indicated she would check the lab book to see if labs were done..."</p> <p>On 06/07/11 at 2:00 P.M., the DoN provided a timeline for the fall intervention for Resident #9. The timeline indicated, "For fall 03/04/11 and 03/05/11, med [medication] review...For fall 5-13-11, encourage...to request assist with transfers/ambulation...For Fall 05/27/11 CBC [complete blood count] CMP [complete metabolic panel]."</p> <p>2. Resident #28's clinical record was reviewed on 6/7/11 at 3:25 p.m. The resident was admitted to the facility on 2/10/09 with diagnoses including, but not limited to, Alzheimer's Disease and osteoporosis. The resident's last full Minimum Data Set [MDS] assessment, a significant change assessment, was dated</p>						

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	<p>3/17/11. The assessment indicated the resident required total assistance of two staff for transfers, and was unable to ambulate. The assessment indicated he had falls since the previous assessment, with no injury. The assessment indicated he utilized bed rails.</p> <p>Resident #28's Side Rail Assessment, dated 3/17/11, indicated the resident had fluctuations in levels of consciousness or a cognitive deficit related to a dementia diagnosis, had visual deficits, was able to get in/out of bed, was not able to get out of bed safely, had a history of falls, used the side rail to help rise from a supine position to a sitting/standing position, had not attempted to climb over the side rails, and there was evidence the resident had a desire or reason to get out of bed, nocturnal toileting. The recommendations were for top half rails to serve as an enabler to promote independence.</p> <p>The resident's Personal Alarm Assessment was dated 3/17/11. It indicated the date of the last fall as 1/18/11 and a history of previous falls. The assessment failed to indicate "unsafe behaviors" of trying to stand, transfer or walk alone, or trying to get out of bed unsafely. The assessment did indicate problems with walking, transfers, toileting, communication, and cognitive ability. The determination was</p>						

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	<p>for the resident to have a tab alarm at all times.</p> <p>Resident #28's care plan was reviewed by facility staff on 3/22/11. The care plan for mobility, dated 3/16/11, indicated a mechanical lift was to be used for the resident's transfers. Resident #28 had a care plan as follows: "[Resident's name] is a fall risk related to: dementia diagnosis, physical limitations and urinary incontinence. Last documented fall: 1/18/2011." Interventions included the following:</p> <ul style="list-style-type: none"> "-Tabs/pad alarm to alert staff of attempts to ambulate/transfer unassisted. Place tabs alarm and clip out of [resident's] reach to ensure proper utilization. Quarterly assessment to determine need for continued alarm use. -Provide [resident] staff assist with transfers/toileting. -Ensure [resident] is wearing appropriate, non-slip footwear. -Ensure that [resident's] frequently used items are within easy reach." <p>Review of Resident #28's nurses' notes included, but were not limited to, the following:</p> <p>1/18/11 10 p.m. "CNAs make rounds found resident laying half way on the floor and bed. Resident on stomach [with] head turned to (R) [right] side and</p>						

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	laying on his arm. (L) [left] leg on floor [with] (R) leg still on the bed, on pad alarm. Able to move all extremities. Has red places on (R) forehead, cheek and (R) shoulder. Assisted up [with] gait belt and iii [three] staff members. At that time, when (R) leg was removed from bed, alarm went off. Resident bed was in lowest position had on gripper socks and alarm working properly." The note was written by a Qualified Medication Assistant [QMA]. 1/18/11 10:15 p.m. "B/P [blood pressure] 156/90 P [pulse] 70 R [respirations] 20 T [temperature] 98.3 02 [oxygen] sat [saturation] 95% on RA [room air]. Sr. [Sister] [name of Nun Supervisor] notified, message left on answering for POA [Power of Attorney]." QMA note. 1/18/11 10:50 p.m. "Dr. [name's] office fax regarding fall on resident." QMA note 1/19/11 12:00 a.m. "Neuro [checks] WNL [within normal limits] B/P 148/80 T. 97.5 P 68 R 18 02 sat: 95% on RA. Resident awakens easily, Denies discomfort..." 2/4/11 11-7 "Resident observed attempting to get out of bed unassisted several times early this shift. Denies discomfort. Care provided, fluids offered...Alarm remains in place." 3/15/11 11:30 p.m. "Resident observed awake, in bed [with] legs off the side of bed. Alarm in place. repositioned back to bed."						

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	<p>4/15/11 3-11 p.m. "A little restless @ beginning of shift, trying to climb out of recliner in his room. CNAs assist [with] Hoyer lift to get resident up. Toileted and put in his wheelchair. Much calmer. Sitting in common area watching T.V..."</p> <p>4/19/11 11:45 p.m. "Resident observed [with] legs off side of bed. Assisted [with] placing legs back on bed...alarm in place."</p> <p>5/1/11 11-7. "Resident has been observed attempting to get out of bed @ X's [at times] this shift. Legs off side of bed, assisted back to bed. Denies discomfort. Alarm remains in place."</p> <p>5/4/11 9:30 p.m. "Tab alarm set off found res. [resident's] lower body on (R) knee on floor - upper body in bed. (R) knee reddened no other bruises or O/A [open areas] observed. Assist back to bed tab alarm on. B/P 140/78 T 98.8 P 93 R 20 02 Sat 95% room air. Has been more confused though."</p> <p>5/4/11 10:15 p.m. "CNA observed resident starting to put legs over side of bed again. Assist back to bed. Tab alarm in place."</p> <p>5/4/11 10:40 p.m. "Dr. [name] notified fax and Sr.[Sister] [name of Nun Supervisor] notified."</p> <p>5/4/11 11:00 p.m. "Resident trying to climb out of bed again."</p> <p>5/10/11 3-11 p.m. "...Once in bed, tried X 3 to get out of bed. Alarm in place and</p>						

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	<p>working properly."</p> <p>5/16/11 8:30 p.m. "Found resident on the floor; sitting [with] back up against the bed. Leaning to the (R) [with] head pressing against side rail. Bed in low position. TAB monitor on and did not engage. ROM [range of motion] adeq. [adequate] to all extremities..."</p> <p>5/17/11 9:30 p.m. "Attempting to climb out of bed X 2. Set tabs monitor off. Wanting to go fishing..."</p> <p>6/4/11 2:45 a.m. "During routine bed check, resident observed sitting upright on floor beside bed. Bed in lowest position. Alarm still attached, did not pull away to sound. AROM [active range of motion] all extremities [without] difficulty. Denies discomfort. B/P 124/70 T 98 P 76 R 18 O2 sat: 96% RA. Assisted to standing position per (3) assist and gait belt. Assisted to bed. [No] redness noted of buttocks or back. Alarm positioned to opposite side of bed and attached to resident's night shirt. Encouraged call light use."</p> <p>There was no indication the care plan was revised when the fall prevention interventions were ineffective.</p> <p>3. Resident #30's clinical record was reviewed on 6/7/11 at 12:07 p.m. The resident's diagnoses included, but were not limited to, Parkinson's disease,</p>						

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	<p>dementia, osteopenia, osteoarthritis, spinal stenosis, chronic obstructive pulmonary disease, and hypertension. The resident's most recent quarterly Minimum Data Set [MDS] assessment, dated 4/21/11, indicated the resident required extensive assistance of 1 for transfers and ambulation, and had not had falls since the last assessment. The resident's most recent Fall Risk assessment was dated 4/20/11 and indicated the resident was at high risk for falls. The resident's Side Rail Assessment, dated 4/21/11, indicated the resident expressed a desire to have the side rails raised for their own safety and/or comfort, had fluctuations in levels of consciousness or a cognitive deficit, had visual deficits, was unable to get out of bed safely, had a history of falls, used the side rails for positioning and support, had not attempted to climb over the side rails, had evidence the resident may have a desire or reason to get out of bed due to nocturnal toileting, and had medications that would require safety precautions, an antidepressant and diuretic.</p> <p>Resident #30's care plan for fall risk potential, dated 4/20/2011, indicated the resident's last documented fall was 01/15/11. Interventions included the following: "-May use mechanical lift for transfers</p>						

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	<p>when [resident] is unable to stand. Encourage [resident] to request assistance with transfers/ambulation. Utilize wheelchair for long-distance locomotion. allow [resident] to perform as much of task as able. Pad alarm in place to bed, chair and wheelchair to alert staff of attempts to ambulate/transfer unassisted. -Ensure [resident] is wearing appropriate non-slip footwear. -Transfer [resident] with gait belt and assist of 2 when she is able/willing to bear weight. Obtain labs per MD orders. -Ensure [resident's] area is free of clutter and that frequently used articles are within easy reach. -Ensure one side of [resident's] bed is up against the wall."</p> <p>Review of Resident #30's nurses' notes included, but was not limited to, the following: 1/11/11 11:25 p.m. "Resident observed sitting upright on floor/closet/in room. [No] c/o [complaint of] discomfort. AROM [active range of motion] all extremities [without] difficulty. Assist of 2 [with] gait belt to standing position. Ambulated [with] i [one] assist, rolling walker to/from bathroom [without] c/o pain or discomfort. Alarm observed on resident's bed. Assisted resident back to bed. Alarm in place. Reminded to use call light prn [as needed] assist."</p>						

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	<p>1/11/11 11:30 p.m. "B/P [blood pressure] 128/64 T [temperature] 97.1 P [pulse] 88 R [respirations] 20 O2 [oxygen] sat [saturation] 95% on RA [room air]. Denies discomfort."</p> <p>1/12/11 1:15 a.m. "Heard noise in hallway near resident's room. Staff to area. Resident observed in hallway outside of her room, seated in her wheelchair. Rolling walker beside wheelchair. Observed resident's night gown to be on backwards, closure strings tied. Alarm observed on bed. Urine on floor. Assisted resident to/from bathroom, skin care provided, gripper socks [changed], floor dried...assisted back to bed. alarm put in place. Again reminded resident to leave alarm in place and to use call light PRN assist..."</p> <p>1/15/11 9:00 p.m. "Had been in bed about 15 minutes when she was found on the floor beside her bed."</p> <p>1/15/11 10:10 p.m. "Had been returned to bed [with] tabs alarm on as before. Now found on floor again. Had pulled blanket up straight on bed. Gown was on backwards. Tabs magnet was clipped to itself so that it would not sound."</p> <p>1/16/11 12:05 a.m. "Resident [up] in recliner by TV on Holy Family Unit as to be under watchful eyes. Tab alarm on (L) [left] side as usual clipped to gown. Second alarm clipped to (R) [right] side and pinned also, she is @ this time</p>						

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	<p>unaware of 2nd tab alarm." 4/25/11 3-11 p.m. "Weekly Summary...Took tabs alarm off once without it sounding and sat on side of bed and was seen and toileted per staff..." 6/4/11 7:15 p.m. "Resident now in recliner. Has sounded alarm X 4 getting up wanting to do things independently. Are monitoring closely."</p> <p>On 6/8/11 at 9:20 a.m., Resident #30 was observed to be seated in her recliner chair at the bedside. The tabs type alarm box was located on the arm of the chair to the right of the resident. The string was clipped to the resident's right shoulder. The alarm box was not attached to anything to stabilize it if the resident attempted to get up.</p> <p>There was no indication the facility reviewed and revised the care plan when fall prevention interventions were ineffective.</p> <p>3.1-35(d)(2)(B)</p>						

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F0281 SS=D	<p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>During observation, interview and record review, the facility failed to ensure gastrostomy tubes were utilized by facility staff in accordance with professional standards, for 1 of 1 sampled resident with a gastrostomy tube, in the sample of 11, in that procedures were not followed to ensure placement of the g-tube prior to feeding and/or medication administration, and sufficient flushes were not administered. (Resident #12)</p> <p>Findings include:</p> <p>Upon interview during and observation of the medication pass, on 06/08/11 at 12:00 P.M., RN #1 indicated she was preparing to administer medications and feeding through a gastrostomy [g-tube]. RN #1 prepared MAPAP (Tylenol) 20 ml [milliliters] 650 mg [milligrams] and placed it in a medication cup. RN #1 obtained 240 ml of Jevity (liquid nutrition), 45 cc [cubic centimeters] of Gatorade, and 30 cc of water, then placed them on a small tray for transport to the resident's room.</p>			F0281	<p>New Policy and Procedures were adopted regarding tube feeding and medication administration with G-tubes. Mandatory in-services were held on June 23, June 24, June 27, and will be held on July 1, 2011, to review the new policies. All nurses and QMAs will have given a return demonstration of tube feeding and medication administration by the completion date. Any new hires will be in-serviced during their orientation. Ongoing in-services will occur quarterly. Nurses and QMAs will be observed one time daily for one month, and then they will be observed weekly for correct administering of tube feeding and medication administration with G-tubes. A copy of the policy and procedure has been posted in the medication room. The ADON and DON will monitor. Ongoing monitoring for one year.</p> <p>Completed date: 07/08/11</p> <p>Mandatory in-services were held on June 14 and June 20, 2011, for all nursing employees. These in-services addressed policy and procedure s for correct handwashing techniques. Nursing staff will be monitored for correct</p>		07/08/2011

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	<p>Resident #12 was observed lying in bed, with the head of bed elevated approximately 30 degrees, on 06/08/11 at 12:00 P.M.</p> <p>RN #1 entered the room and set the small tray of prepared medications on the bedside cabinet.</p> <p>RN #1 was then observed to enter the resident's bathroom and perform handwashing for 10 seconds.</p> <p>RN #1 was then observed to apply gloves.</p> <p>RN #1 was then observed to remove a 60 cc syringe from a plastic container. The syringe and the container were observed to have a tan liquid residue.</p> <p>In an interview at that time, RN #1 indicated, "That is from the previous feeding."</p> <p>RN #1 was then observed to install a 30 cc air bolus to the open port of the g-tube.</p> <p>RN #1 was then observed to remove the stethoscope from around her neck and apply the bell of the stethoscope to the resident's abdomen.</p> <p>During an interview at that time, RN #1</p>				<p>technique five times a week for one month. Monitoring will continue twice weekly for randomly selected employees. All new nursing employees will be in-serviced on correct handwashing techniques during orientation. Ongoing in-servicing will occur bi-annually. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 06/30/11</p>		

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	<p>indicated, "Oh, I heard sounds."</p> <p>RN #1 was then observed to perform a residual check without success. This procedure was repeated 3 times without residual being obtained.</p> <p>During an interview at that time, RN #1 indicated, "What do you want me to do?" Upon query of what RN #1 would normally do, she indicated, "I would go check with the ADoN [Assistant Director of Nurses]."</p> <p>RN #1 was then observed to remove gloves, perform handwashing for 8 seconds, and exit the room, leaving the medications unsupervised.</p> <p>RN #1 was then observed to re-enter the room and indicated, "There doesn't always have to be a residual." RN #1 was then observed to enter the bathroom of Resident #13 and perform handwashing for 5 seconds.</p> <p>RN #1 was then observed to apply gloves and pull Jevity up in a 60 cc syringe.</p> <p>RN #1 then released the Jevity back into the cup, wiped the tip of the syringe with a Kleenex, and inserted the tip of the 60 cc syringe into the open port of the tube.</p>						

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	<p>RN #1 was then observed to pour Jevity into the open 60 cc syringe, spilling a copious amount onto the resident's abdomen. During the bolus feeding, the syringe tip was observed to disengage from the tube, spilling more Jevity onto the resident's abdomen.</p> <p>RN #1 was then observed to hold the syringe, attached to the tube in her left hand, and reach around her body to retrieve needed supplies from the bedside cabinet, applying tension to the tube.</p> <p>RN #1 was then observed to put the syringe and tube back together and complete the bolus feeding.</p> <p>RN #1 was then observed to administer MAPAP 20 ml [equals 650 milligrams] via tube without performing a flush after the feeding and before medication administration. RN #1 was then observed to fill the open syringe, attached to the tube, with Gatorade, then pour it back into its cup and fill the open syringe with 30 cc water. At that time, the tube and the open syringe disengaged and water spilled onto Resident #12's abdomen.</p> <p>RN #1 was then observed to fill the open syringe with Gatorade and the open syringe disengaged, with Gatorade spilling onto Resident #12 abdomen. RN</p>						

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	<p>#1 then indicated, "That has never happened to me in all my years of nursing."</p> <p>RN #1 was then observed to rinse the syringe with water, remove her gloves and perform handwashing for 10 seconds.</p> <p>RN #1 was then observed to apply gloves and wipe the syringe with a paper towel. The syringe was observed, at that time, to have water droplets on the inner lower half. RN #1 was then observed to return the syringe to the plastic container that was observed to still have the tan liquid residue.</p> <p>RN #1 was then observed to remove gloves and perform handwashing for 10 seconds. RN #1 was then observed to apply gloves and put supplies away. RN #1 was then observed to remove gloves and perform handwashing for 11 seconds.</p> <p>In an interview with RN #1 at that time, she indicated that she estimated Resident #12 had received 220 ml of feeding and 60 cc of water and Gatorade</p> <p>In an interview with the DoN, on 06/08/11 at 4:30 P.M., she indicated, "The orders for the tube are right there on the MAR, she should have known what to do... We just inserviced on that and handwashing."</p>						

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	<p>During an interview with the DoN, on 06/10/11 at 12:20 P.M., she indicated if the nurses had questions about g-tubes, they would ask her and she would look on the internet. The DoN indicated the resources that she had in the facility were from 1980 and 1987.</p> <p>RN #2 was observed administering medications and feeding solution to Resident #12 on 6/8/11 at 5:50 p.m. She crushed Metoprolol [blood pressure medication] and Ranitidine [medication to reduce stomach acid] together and placed them in a medication cup with 10 cubic centimeters [cc] of water. She had already crushed what she identified as Calcium with Vitamin D; she obtained a medication cup with a powdery substance and flakes of an outer coating in it. She poured the substance into a drinking cup and measured 10 cc of water and added it to the cup. She then stirred and attempted to dissolve the Calcium pill in the water. She then indicated she needed 10 cc more water to make up the 30 cc water flush ordered by the physician. She put about 15 cc of water into a medicine cup. She then poured up 45 cc of Gatorade. She also obtained a can of Jevity 1.2 feeding solution.</p> <p>CNA #2 approached RN #2 and told her</p>						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 06/14/2011	
NAME OF PROVIDER OR SUPPLIER ST JOHNS HOME FOR THE AGED				STREET ADDRESS, CITY, STATE, ZIP CODE 1236 LINCOLN AVENUE EVANSVILLE, IN47714			
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	<p>Resident #12 was complaining of stomach pain. RN #2 indicated she would check on the resident, "maybe it will help if I give this [indicating the medication and feeding]." She indicated the resident might also be complaining of the g-tube site.</p> <p>RN #2 took everything to the resident's room on a plastic tray. She put on gloves and uncovered the resident's abdomen. A gauze dressing was observed around the g-tube at the insertion site. It was soiled with beige solution with some pink tinges. She removed the dressing.</p> <p>With the same gloves, she proceeded to get a syringe out, contained in a plastic container at the bedside. She attached the syringe to the end of the gastrostomy tube and pulled back on the plunger. Nothing entered the syringe chamber. She indicated, "usually don't get anything back, maybe a dribble." She disconnected the syringe and a couple drops of liquid dropped onto kleenex she had placed on the resident's abdomen. "I guess that's all the residual I'm going to get," she stated. She proceeded to take the plunger out of the syringe and attach the syringe chamber to the gastrostomy tube, to administer the medications and feeding to the tube. At that time, she was stopped from proceeding and queried, "Did you get</p>						

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	<p>enough residual to assure yourself it [the tube] is in the stomach?" She indicated, "I guess I didn't." At that time, she put the syringe down, took off her gloves, exited the room, and returned with a stethoscope. She then put on new gloves, injected air into the gastrostomy tube and listened with the stethoscope to the abdomen, indicating she heard air entering the stomach.</p> <p>At that time, she disconnected the syringe, pulled the plunger out and reattached the syringe to the tube. She poured the Calcium tablet in the 10 cc of water into the tube. Medication was left in the medication cup. She opened the can of feeding and poured it into the medication cup, mixing with the remaining Calcium tablet and administered via gravity through the tube. She then administered the other two medications, in the 10 cc of fluid. That was followed by the Gatorade and then the last 15 cc cup of water.</p> <p>The policy and procedure for Tube Feeding by Gravity/Bolus, dated 7/2005, was provided by the Director of Nurses on 6/8/11 at 5:15 p.m. The policy and procedure included, but was not limited to, the following: "5. Before beginning feed always check for correct placement of tube. Insert 30 CC of air from syringe into gastric (sic)</p>						

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	<p>tube while holding stethoscope over epigastrium to listen for influx of air.</p> <p>6. Check for residual feeding. See Physician's orders for instructions.</p> <p>7. Attach syringe to end of gastric tube. Pour feeding into syringe, if by gravity, hold syringe upright to facilitate draining until all feeding solution is completed. If by bolus gently push plunger down to drain the syringe of feeding until correct (sic) amount of tube feeding has been given.</p> <p>8. After feeding is complete, flush tube per physicians's (sic) orders."</p> <p>The policy and procedure for "Medication-Feeding Tube," dated 7/2005, was provided by the Director of Nurses on 6/9/11 at 1:45 p.m. The procedure indicated placement and patency by auscultation was to be checked by attaching the syringe to the end of the tube and inserting twenty cubic centimeters of air and listening for the air. The policy also indicated the tube was to be flushed with thirty (30) cc of water after administration of the medications.</p> <p>The Geriatric Medication Handbook, Eighth Edition, reviewed on 6/9/11 at 2:00 p.m., indicated the following: "Medication administration via enteral tubes procedures: ...8. Check for proper tube placement...12. Put 15-30 ml</p>						

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	<p>[milliliters] water in syringe and flush tubing using gravity flow...13. Pour dissolved/diluted medication in syringe...14. Flush tubing with 15-30 ml of water, or prescribed amount..."</p> <p>The Indiana State Board of Nursing compilation of the Indiana Code and Indiana Administrative Code 2009 Edition indicated, "848 IAC 2-2-2 Responsibility as a member of the nursing profession Authority: IC 25-23-1-7 Affected: IC 25-23 Sec. 2. The registered nurse shall do the following: ...(3) Communicate, collaborate, and function with other members of the health team to provide safe and effective care. (4) Seek education and supervision as necessary when implementing nursing practice techniques." "48 IAC 2-2-3 Unprofessional conduct Authority: IC 25-23-1-7 Affected: IC 25-23 Sec. 3. Nursing behaviors (acts, knowledge, and practices) failing to meet the minimal standards of acceptable and prevailing nursing practice, which could jeopardize the health, safety, and welfare of the public, shall constitute unprofessional conduct. These behaviors shall include, but are not limited to, the following: (1) Using unsafe judgment, technical skills, or inappropriate interpersonal behaviors in providing nursing care. (2) Performing any nursing technique or procedure for which the nurse is unprepared by education or experience."</p> <p>3.1-35(g)(1)</p>						

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure the written plan of care was followed, for 2 of 3 sampled residents, in regards to incontinence care (residents' #29, #12), and for 1 of 1 resident reviewed for gastrostomy tube care (resident #12), in the sample of 11.</p> <p>Findings include:</p> <p>1. On 6/7/11 at 8:45 a.m., CNAs #3 and #4 were observed to take Resident #29 to the bathroom. They transferred resident # 29 to the toilet with a sit to stand lift. The resident had a pull-up type incontinence brief on. During interview at that time, both CNAs indicated the brief was wet. The brief was removed and the resident was seated on the toilet and had a bowel movement while there.</p> <p>When the resident was done, the CNAs stood her up with the lift, wiped her with</p>		F0282	<p>Mandatory in-services were held for all nursing employees on June 14 and June 20, 2011, addressing incontinence care and peri-care. CNAs will be monitored five times weekly providing peri-care for one month. Monitoring will continue twice weekly for randomly selected employees. All new employees will be in-serviced on peri-care during the orientation process and ongoing in-servicing will occur bi-annually. The Charge nurse, ADON, and DON will monitor. Ongoing monitoring for one year. Completed 06/22/11</p> <p>New policy and procedures were adopted regarding tube feeding and medication administration with G-tubes. Mandatory in-services were held on June 23, June 24, June 27, and will be held on July 1, 2011, reviewing the new policies. All nurses and QMAs will have given a return demonstration of tube feeding and medication administration by the completion date. Ongoing in-services will occur quarterly. Nurses and QMAs will be</p>		07/08/2011	

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	<p>toilet paper, put a clean incontinence product on her, dressed her and assisted her back to the wheelchair. There was no cleansing of the perineal area and thighs following the incontinence of urine.</p> <p>Resident #29's clinical record was reviewed on 6/9/11 at 10:00 a.m.</p> <p>Resident #29's care plan regarding incontinence, dated 4/14/11, indicated she was to be checked and changed and provided hygiene every 2 hours and as needed.</p> <p>2. On 6/8/11 at 5:20 p.m., CNAs #1 and #2 were observed assisting Resident #12 to the bathroom. The resident was walked to the bathroom with a walker and two assist. A pull-up type of incontinence brief was removed. It was wet and soiled with a smear of feces.</p> <p>After giving the resident time on the toilet, CNA #2 washed the resident's perineal area by reaching through the legs from the front and, using wash cloths, washing the area from back to front. The CNAs placed a clean incontinence brief on the resident. As the resident stood up, she started to urinate. The staff walked with her back to the bed. They then removed the brief and obtained wet and soapy paper towels from the bathroom</p>				<p>observed once daily for one month, and then weekly for correct administering of tube feeding and medication administration of G-tubes. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 07/08/11</p> <p>Mandatory in-services were held on June 14 and June 20, 2011 for all nursing employees addressing policies and procedures for correct handwashing techniques. Nursing staff will be monitored for correct handwashing techniques five times weekly for one month. Monitoring will continue twice weekly for randomly selected employees. All new nursing employees will be in-serviced on correct handwashing techniques during orientation. Ongoing in-services will occur bi-annually. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 06/30/11</p>		

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	<p>and washed, rinsed, and dried the resident again using the brown paper towels from the bathroom. CNA #1 stated, "No wash cloths, using what I have."</p> <p>When the observation was reviewed with the Director of Nurses, on 6/8/11 at 6:50 p.m., upon interview at that time she stated, "of course they should have gone and got wash cloths." She further indicated an inservice on perineal care had been done not too long ago and the staff should know not to wash back to front.</p> <p>Resident #12's clinical record was reviewed on 6/7/11 at 10:10 a.m. The resident had a care plan, dated 5/17/11, for urinary incontinence. The interventions included, but were not limited to, "Staff to assist [Resident's name] with post void hygiene."</p> <p>The policy and procedure for care of incontinence, dated 5/2006, was provided by the Director of Nurses on 6/13/11 at 1:00 p.m. The policy indicated, "Residents are washed and changed when wet or soiled."</p> <p>During an observation of the medication pass, on 06/08/11 at 12:00 P.M., RN #1 indicated she was preparing to administer medications and feeding through a g-tube to resident # 12. RN #1 prepared MAPAP</p>						

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	<p>(Tylenol) 20 ml [milliliters] (650 mg) and placed it in a medication cup. RN #1 obtained 240 ml of Jevity (liquid nutrition), 45 cc [cubic centimeters] of Gatorade, and 30 cc of water and placed them on a small tray for transport to resident's room.</p> <p>Resident #12 was observed lying in bed, with the head of bed elevated approximately 30 degrees, on 06/08/11 at 12:00 P.M.</p> <p>RN #1 entered room and set the small tray of prepared medications on the bedside cabinet. RN #1 was then observed to enter the resident's bathroom and perform handwashing for 10 seconds. RN#1 was then observed to apply gloves. RN#1 was then observed to remove a 60 cc syringe from a plastic container. The syringe and the container was observed to have a tan liquid residue. In an interview at that time, RN #1 indicated, "That is from the previous feeding."</p> <p>RN #1 was then observed to install a 30 cc air bolus to the open port of the g-tube. RN#1 was then observed to remove the stethoscope from around her neck and apply the bell of the stethoscope to the resident's abdomen. RN#1 indicated, "Oh, I heard sounds."</p>						

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	<p>RN #1 was then observed to perform a residual check without success. This procedure was repeated 3 times without residual being obtained. During an interview at that time, RN #1 indicated, "What do you want me to do?" Upon query of what RN #1 would normally do, she indicated, "I would go check with the ADoN."</p> <p>RN #1 was then observed to remove gloves, perform handwashing for 8 seconds, and exit the room, leaving the medications unsupervised.</p> <p>RN #1 was then observed to re-enter the room and indicated, "There doesn't always have to be a residual." RN #1 was then observed to enter the bathroom of Resident #12 and perform handwashing for 5 seconds. RN#1 was then observed to apply gloves and pull Jevity up in a 60 cc syringe. RN #1 then released the Jevity back into the cup, wiped the tip of the syringe with a Kleenex, and inserted the tip of the 60 cc syringe into the open port of the tube.</p> <p>RN #1 was then observed to pour Jevity into the open 60 cc syringe, spilling a copious amount onto the residents abdomen. During the bolus feeding, the syringe tip was observed to disengage from the tube, spilling Jevity onto the</p>						

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	<p>residents abdomen.</p> <p>RN #1 was observed to hold the syringe, attached to the tube in her left hand, and reach around her body to retrieve needed supplies from the bedside cabinet, applying tension to the tube.</p> <p>RN#1 was then observed to put the syringe and tube back together and complete the bolus feeding.</p> <p>RN #1 was then observed to administer MAPAP 20 ml [equals 650 milligrams] via tube without performing a flush after the feeding and before medication administration. RN #1 was then observed to fill the open syringe attached to the tube with Gatorade the pour it back into its cup and fill the open syringe with 30 cc water. At that time, the tube and the open syringe disengaged and water spilled onto Resident #12's abdomen. RN #1 was then observed to fill the open syringe with Gatorade and the open syringe disengaged with Gatorade spilling on the Resident #12 abdomen.</p> <p>RN #1 was then observed to rinse the syringe with water, remove her gloves and perform handwashing for 10 seconds. RN #1 was then observed to apply gloves and wipe the syringe with a paper towel. The syringe was observed to have water</p>						

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	<p>droplets on the inner lower half. RN #1 was then observed to return the syringe to the plastic container that was observed to still have the tan liquid residue. RN #1 was then observed to remove gloves and perform handwashing for 10 seconds.</p> <p>RN #1 was then observed to apply gloves and put supplies away. RN #1 was then observed to remove gloves and perform handwashing for 11 seconds. In an interview with RN #1, at that time, she indicated she estimated Resident #12 had received 220 ml of feeding and 60 cc of water and Gatorade.</p> <p>In an interview with the DoN, on 06/08/11 at 4:30 P.M., she indicated, "The orders for the tube are right there on the MAR, she should have known what to do... We just inserviced on that and handwashing."</p> <p>RN #2 was observed administering medications and feeding solution to Resident #12 on 6/8/11 at 5:50 p.m. She crushed Metoprolol [blood pressure medication] and Ranitidine [medication to reduce stomach acid] together and placed them in a medication cup with 10 cubic centimeters [cc] of water. She had already crushed what she identified as Calcium with Vitamin D; she obtained a medication cup with a powdery substance and flakes of an outer coating in it. She</p>						

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	<p>poured the substance into a drinking cup and measured 10 cc of water and added it to the cup. She then stirred and attempted to dissolve the Calcium pill in the water. She then indicated she needed 10 cc more water to make up the 30 cc water flush ordered by the physician. She put about 15 cc of water into a medicine cup. She then poured up 45 cc of Gatorade. She also obtained a can of Jevity 1.2 feeding solution.</p> <p>CNA #2 approached RN #2 and told her Resident #12 was complaining of stomach pain. RN #2 indicated she would check on the resident, "maybe it will help if I give this [indicating the medication and feeding]." She indicated the resident might also be complaining of the g-tube site.</p> <p>RN #2 took everything to the resident's room on a plastic tray. She put on gloves and uncovered the resident's abdomen. A gauze dressing was observed around the g-tube at the insertion site. It was soiled with beige solution with some pink tinges. She removed the dressing.</p> <p>With the same gloves, she proceeded to get a syringe out, contained in a plastic container at the bedside. She attached the syringe to the end of the gastrostomy tube and pulled back on the plunger. Nothing</p>						

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	<p>entered the syringe chamber. She indicated, "usually don't get anything back, maybe a dribble." She disconnected the syringe and a couple drops of liquid dropped onto kleenex she had placed on the resident's abdomen. "I guess that's all the residual I'm going to get," she stated. She proceeded to take the plunger out of the syringe and attach the syringe chamber to the gastrostomy tube, to administer the medications and feeding to the tube. At that time, she was stopped from proceeding and queried, "Did you get enough residual to assure yourself it [the tube] is in the stomach?" She indicated, "I guess I didn't." At that time, she put the syringe down, took off her gloves, exited the room, and returned with a stethoscope. She then put on new gloves, injected air into the gastrostomy tube and listened with the stethoscope to the abdomen, indicating she heard air entering the stomach.</p> <p>At that time, she disconnected the syringe, pulled the plunger out and reattached the syringe to the tube. She poured the Calcium tablet in the 10 cc of water into the tube. Medication was left in the medication cup. She opened the can of feeding and poured it into the medication cup, mixing with the remaining Calcium tablet and administered via gravity through the tube. She then administered</p>						

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	<p>the other two medications, in the 10 cc of fluid. That was followed by the Gatorade and then the last 15 cc cup of water.</p> <p>Resident #12's clinical record was reviewed on 6/7/11 at 10:10 a.m. She had a care plan, dated 5/17/11, for her gastric tube. The interventions included, but were not limited to, the following: "-Maintain [Resident's name] gastrostomy tube for feeding/medicating purposes. -check residual, positioning of tube prior to feed/med pass. Give 30 cc of H2O [water] and 45 cc of sports drink via tube after each feeding and med pass. Check [Resident's] lung sounds prior to and following each feeding."</p> <p>3.1-35(h)</p>						
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.						

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	<p>Based on observation, interview and record review, the facility failed to ensure 2 of 3 sampled residents observed during incontinence care, in the sample of 11, received appropriate personal hygiene, in that cleansing of the perineal area was not done, and/or was not thorough or appropriate. (Residents #12, #29)</p> <p>Findings include:</p> <p>1. On 6/7/11 at 8:45 a.m., CNAs #3 and #4 were observed to take Resident #29 to the bathroom. They transferred her to the toilet with a sit to stand lift. The resident had a pull-up type incontinence brief on. During interview at that time both CNAs indicated the brief was wet. The brief was removed, the resident was seated on the toilet and had a bowel movement while there.</p> <p>When the resident was done, the CNAs stood her up with the lift, wiped her with toilet paper, put a clean incontinence product on her, dressed her and assisted her back to the wheelchair. There was no cleansing of the perineal area and thighs following the incontinence of urine.</p> <p>Resident #29's clinical record was reviewed on 6/9/11 at 10:00 a.m. Resident #29's care plan regarding incontinence, dated 4/14/11, indicated she</p>			F0312	<p>Mandatory in-services were held for all nursing employees on June 14 and June 20, 2011 addressing peri and incontinence care procedures. CNAs will be monitored providing peri-care five times a week for one month. Monitoring will continue twice weekly for randomly selected employees. All new employees will be in-serviced on peri-care during the orientation process and ongoing bi-annual in-servicing addressing peri-care will occur. The charge nurse, ADON and DON will monitor. Ongoing monitoring for one year.</p>		06/30/2011

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	<p>was to be checked and changed and provided hygiene every 2 hours and as needed.</p> <p>2. On 6/8/11 at 5:20 p.m., CNAs #1 and #2 were observed assisting Resident #12 to the bathroom. The resident was walked to the bathroom with a walker and two assist. A pull-up type of incontinence brief was removed. It was wet and soiled with a smear of feces.</p> <p>After giving the resident time on the toilet, CNA #2 washed the resident's perineal area by reaching through the legs from the front and, using wash cloths, washing the area from back to front. The CNAs placed a clean incontinence brief on the resident. As the resident stood up, she started to urinate. The staff walked with her back to the bed. They then removed the brief and obtained wet and soapy paper towels from the bathroom and washed, rinsed, and dried the resident again using the brown paper towels from the bathroom. During interview at that time, CNA #1 stated, "No wash cloths, using what I have."</p> <p>When the observation was reviewed with the Director of Nurses, on 6/8/11 at 6:50 p.m., upon interview at that time she stated, "of course they should have gone and got wash cloths." She further</p>						

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	<p>indicated an inservice on perineal care had been done not too long ago and the staff should know not to wash back to front.</p> <p>Resident #12's clinical record was reviewed on 6/7/11 at 10:10 a.m. The resident had a care plan, dated 5/17/11, for urinary incontinence. The interventions included, but were not limited to, "Staff to assist [Resident's name] with post void hygiene."</p> <p>3. The policy and procedure for care of incontinence, dated 5/2006, was provided by the Director of Nurses on 6/13/11 at 1:00 p.m. The policy indicated, "Residents are washed and changed when wet or soiled."</p> <p>3.1-38(a)(3)(A)</p>						

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F0322 SS=D	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident with a gastrostomy tube, in the sample of 11, was provided appropriate treatment and services to prevent potential complications, in that placement was not checked prior to administration of feedings and/or medications, flushes were not adequate, and infection control practices were deficient. (Resident #12)</p> <p>Findings include:</p> <p>During an observation of the medication pass, on 06/08/11 at 12:00 P.M., upon interview at that time, RN #1 indicated she was preparing to administer medications and feeding through a g-tube. RN #1 prepared MAPAP (Tylenol) 20 ml [milliliters] (650 mg) and placed in a medication cup. RN #1 obtained 240 ml of Jevity (liquid nutrition), 45 cc [cubic centimeters] of Gatorade, and 30 cc of water and placed them on a small tray for transport to resident's room.</p>			F0322	<p>New policy and procedures were adopted regarding tube feeding and medication administration with G-tubes. Mandatory in-services were held on June 23, June 24, June 27, and will be held on July 1, 2011, reviewing the new policies. All nurses and QMAs will have given a return demonstration of tube feeding and medication administration by the completion date. Ongoing in-services will occur quarterly. Nurses and QMAs will be observed once daily for one month, and then weekly for correct administering of tube feeding and medication administration of G-tubes. The ADON and DON will monitor. Ongoing monitoring for one year.</p> <p>Completed date: 07/08/11</p> <p>Mandatory in-services were held on June 14 and June 20, 2011 for all nursing employees addressing policies and procedures for correct handwashing techniques. Nursing staff will be monitored for correct handwashing techniques five times weekly for one month. Monitoring will continue twice weekly for randomly selected employees. All new nursing</p>		07/08/2011

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	<p>Resident #12 was observed lying in bed, with the head of bed elevated approximately 30 degrees, on 06/08/11 at 12:00 P.M.</p> <p>RN #1 entered room and set the small tray of prepared medications on the bedside cabinet. RN #1 was then observed to enter the resident's bathroom and perform handwashing for 10 seconds. RN#1 was then observed to apply gloves. RN#1 was then observed to remove a 60 cc syringe from a plastic container. The syringe and the container was observed to have a tan liquid residue. In an interview at that time, RN #1 indicated, "That is from the previous feeding."</p> <p>RN #1 was then observed to install a 30 cc air bolus to the open port of the g-tube. RN#1 was then observed to remove the stethoscope from around her neck and apply the bell of the stethoscope to the resident's abdomen. RN#1 indicated, "Oh, I heard sounds."</p> <p>RN #1 was then observed to perform a residual check without success. This procedure was repeated 3 times without residual being obtained. During an interview at that time, RN #1 indicated, "What do you want me to do?" Upon query of what RN #1 would normally do,</p>				<p>employees will be in-serviced on correct handwashing techniques during orientation. Ongoing in-services will occur bi-annually. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 06/30/11</p> <p>Mandatory in-services were held on June 20, June 23, June 27, and will be held on July 1, 2011, regarding correct glove usage with procedures. Proper glove usage will be monitored five times a week for one month. Monitoring will continue twice weekly for randomly selected employees. All new nursing employees will be in-serviced on proper glove usage during orientation. Ongoing in-services will be held bi-annually. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 07/08/11</p>		

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	<p>she indicated, "I would go check with the ADON."</p> <p>RN #1 was then observed to remove gloves, perform handwashing for 8 seconds, and exit the room, leaving the medications unsupervised.</p> <p>RN #1 was then observed to re-enter the room and indicated, "There doesn't always have to be a residual." RN #1 was then observed to enter the bathroom of Resident #12 and perform handwashing for 5 seconds. RN#1 was then observed to apply gloves and pull Jevity up in a 60 cc syringe. RN #1 then released the Jevity back into the cup, wiped the tip of the syringe with a Kleenex, and inserted the tip of the 60 cc syringe into the open port of the tube.</p> <p>RN #1 was then observed to pour Jevity into the open 60 cc syringe, spilling a copious amount onto the residents abdomen. During the bolus feeding, the syringe tip was observed to disengage from the tube, spilling Jevity onto the residents abdomen.</p> <p>RN #1 was observed to hold the syringe, attached to the tube in her left hand, and reach around her body to retrieve needed supplies from the bedside cabinet, applying tension to the tube.</p>						

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	<p>RN#1 was then observed to put the syringe and tube back together and complete the bolus feeding.</p> <p>RN #1 was then observed to administer MAPAP 20 ml [equals 650 milligrams] via tube without performing a flush after the feeding and before medication administration. RN #1 was then observed to fill the open syringe attached to the tube with Gatorade the pour it back into its cup and fill the open syringe with 30 cc water. At that time, the tube and the open syringe disengaged and water spilled onto Resident #12's abdomen. RN #1 was then observed to fill the open syringe with Gatorade and the open syringe disengaged with Gatorade spilling on the Resident #12 abdomen. RN #1 then indicated, "That has never happened to me in all my years of nursing."</p> <p>RN #1 was then observed to rinse the syringe with water, remove her gloves and perform handwashing for 10 seconds. RN #1 was then observed to apply gloves and wipe the syringe with a paper towel. The syringe was observed to have water droplets on the inner lower half. RN #1 was then observed to return the syringe to the plastic container that was observed to still have the tan liquid residue. RN #1 was then observed to remove gloves and</p>						

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	<p>perform handwashing for 10 seconds.</p> <p>RN #1 was then observed to apply gloves and put supplies away. RN #1 was then observed to remove gloves and perform handwashing for 11 seconds. In an interview with RN #1, at that time, she indicated she estimated Resident #12 had received 220 ml of feeding and 60 cc of water and Gatorade.</p> <p>In an interview with the DoN, on 06/08/11 at 4:30 P.M., she indicated, "The orders for the tube are right there on the MAR, she should have known what to do... We just inserviced on that and handwashing." RN #2 was observed administering medications and feeding solution to Resident #12 on 6/8/11 at 5:50 p.m. She crushed Metoprolol [blood pressure medication] and Ranitidine [medication to reduce stomach acid] together and placed them in a medication cup with 10 cubic centimeters [cc] of water. She had already crushed what she identified as Calcium with Vitamin D; she obtained a medication cup with a powdery substance and flakes of an outer coating in it. She poured the substance into a drinking cup and measured 10 cc of water and added it to the cup. She then stirred and attempted to dissolve the Calcium pill in the water. She then indicated she needed 10 cc more water to make up the 30 cc water flush</p>						

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	<p>ordered by the physician. She put about 15 cc of water into a medicine cup. She then poured up 45 cc of Gatorade. She also obtained a can of Jevity 1.2 feeding solution.</p> <p>CNA #2 approached RN #2 and told her Resident #12 was complaining of stomach pain. RN #2 indicated she would check on the resident, "maybe it will help if I give this [indicating the medication and feeding]." She indicated the resident might also be complaining of the g-tube site.</p> <p>RN #2 took everything to the resident's room on a plastic tray. She put on gloves and uncovered the resident's abdomen. A gauze dressing was observed around the g-tube at the insertion site. It was soiled with beige solution with some pink tinges. She removed the dressing.</p> <p>With the same gloves, she proceeded to get a syringe out, contained in a plastic container at the bedside. She attached the syringe to the end of the gastrostomy tube and pulled back on the plunger. Nothing entered the syringe chamber. She indicated, "usually don't get anything back, maybe a dribble." She disconnected the syringe and a couple drops of liquid dropped onto kleenex she had placed on the resident's abdomen. "I guess that's all</p>						

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	<p>the residual I'm going to get," she stated. She proceeded to take the plunger out of the syringe and attach the syringe chamber to the gastrostomy tube, to administer the medications and feeding to the tube. At that time, she was stopped from proceeding and queried, "Did you get enough residual to assure yourself it [the tube] is in the stomach?" She indicated, "I guess I didn't." At that time, she put the syringe down, took off her gloves, exited the room, and returned with a stethoscope. She then put on new gloves, injected air into the gastrostomy tube and listened with the stethoscope to the abdomen, indicating she heard air entering the stomach.</p> <p>At that time, she disconnected the syringe, pulled the plunger out and reattached the syringe to the tube. She poured the Calcium tablet in the 10 cc of water into the tube. Medication was left in the medication cup. She opened the can of feeding and poured it into the medication cup, mixing with the remaining Calcium tablet and administered via gravity through the tube. She then administered the other two medications, in the 10 cc of fluid. That was followed by the Gatorade and then the last 15 cc cup of water.</p> <p>Resident #12's clinical record was reviewed on 6/7/11 at 10:10 a.m. She had</p>						

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	<p>a care plan, dated 5/17/11, for her gastric tube. The interventions included, but were not limited to, the following:</p> <p>"-Maintain [Resident's name] gastrostomy tube for feeding/medicating purposes.</p> <p>-check residual, positioning of tube prior to feed/med pass. Give 30 cc of H2O [water] and 45 cc of sports drink via tube after each feeding and med pass. Check [Resident's] lung sounds prior to and following each feeding."</p> <p>The policy and procedure for Tube Feeding by Gravity/Bolus, dated 7/2005, was provided by the Director of Nurses on 6/8/11 at 5:15 p.m. The policy and procedure included, but was not limited to, the following:</p> <p>"5. Before beginning feed always check for correct placement of tube. Insert 30 CC of air from syringe into gastric (sic) tube while holding stethoscope over epigastrium to listen for influx of air.</p> <p>6. Check for residual feeding. See Physician's orders for instructions.</p> <p>7. Attach syringe to end of gastric tube. Pour feeding into syringe, if by gravity, hold syringe upright to facilitate draining until all feeding solution is completed. If by bolus gently push plunger down to drain the syringe of feeding until correct (sic) amount of tube feeding has been given.</p> <p>8. After feeding is complete, flush tube</p>						

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	<p>per physicians's (sic) orders."</p> <p>The policy and procedure for "Medication-Feeding Tube," dated 7/2005, was provided by the Director of Nurses on 6/9/11 at 1:45 p.m. The procedure indicated placement and patency by auscultation was to be checked by attaching the syringe to the end of the tube and inserting twenty cubic centimeters of air and listening for the air. The policy also indicated the tube was to be flushed with thirty (30) cc of water after administration of the medications.</p> <p>A policy and procedure for Handwashing, dated 05/2006, provided by the DoN on 06/08/11 at 5:15 P.M., indicated, "Policy All staff providing direct patient care or having any physical contact with resident or their equipment shall wash their hands frequently. This will include, but is not limited to: 2. Between contact with different Resident 3. Before and after any physical contact with Resident equipment or personal article... Before and after any procedure with Resident...7. After the removal of gloves... Procedure...2. lather hands and rub vigorously for ten to fifteen (10-15) seconds."</p> <p>The Geriatric Medication Handbook, Eighth Edition, reviewed on 6/9/11 at</p>						

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F0323 SS=K	2:00 p.m., indicated the following: "Medication administration via enteral tubes procedures: ...8. Check for proper tube placement...12. Put 15-30 ml [milliliters] water in syringe and flush tubing using gravity flow...13. Pour dissolved/diluted medication in syringe...14. Flush tubing with 15-30 ml of water, or prescribed amount..." 3.1-44(a)(2)						
	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview and record review, the facility failed to ensure side rails were safe, in that gaps between the slats exceeded 4 and 3/4 inches, with potential for entrapment of head/neck or limbs, and failed to ensure residents were			F0323	When the facility was notified of the deficient practice, all side rails were immediately assessed and measured. Side rails that exceeded 4 and 3/4 inches were covered. All bottom side rails were removed. Starting on June		07/14/2011

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	<p>provided supervision and assistive devices to prevent falls, with potential for serious injury, in that interventions were not always in place and new interventions were not attempted when interventions were unsuccessful. This deficient practice affected 8 of 11 sampled residents with falls and/or side rail gaps, and 19 of 19 supplemental sample residents with side rail gaps, in the supplemental sample of 29. (Residents #15, #41, #10, #12, #23, #30, #14, #21, #22, #16, #42, #6, #19, #20, #5, #13, #18, #31, #7, #40, #2, #35, #1, #37, #11, #9, #28)</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy began on 6/7/11. The Facility Administrator, President of the facility, and the Director of Nurses [DoN] were notified of the Immediate Jeopardy on 6/7/11. The Immediate Jeopardy was removed on 6/11/11, but the facility remained out of compliance at the level of pattern no actual harm with the potential for more than minimal harm, because the facility still needed to obtain permanent side rail kits to fill the gaps, monitor to ensure the temporary fix remained intact until the permanent side rail kits arrived, continue to monitor interventions to prevent falls for their effectiveness and revise interventions as necessary.</p>				<p>9, 2011, the side rail covers were monitored every shift to ensure the covers and tape were secure. Also on this date, the side rail kits were ordered. Monitoring continued every shift until all the side rail kits were received and installed. All side rail kits have been installed. If new beds are received in the facility, the maintenance department will examine each bed's side rails for compliance. Compliance will be monitored by the maintenance department. Completed 06/24/11 Mandatory in-services were held on June 23, June 24, June 27, and will be held on July 1, 2011, addressing proper storage of chemicals. Chemicals were removed and placed in a locked cabinet. All chemicals will be under lock and key when not in use. Soiled utility rooms will be monitored every shift for unlocked or unattended chemicals. The charge nurse, ADON, and DON will monitor. Ongoing monitoring for one year. Completed date: 07/02/11 Medication in-services will be held on July 7 and July 8, 2011, for nurses and QMAs addressing medications left unattended and outside the view of the nurse. Nurses and QMAs will be monitored five times a week for one month. Monitoring will continue twice weekly for compliance. New hires will be in-serviced regarding this issue during the orientation process and ongoing in-services will be</p>		

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	<p>B. Based on observation, interview and record review, the facility failed to ensure the environment was free of accident hazards, for 30 of 42 residents identified as cognitively impaired, in that chemicals were unlocked and unattended, medications were left on top of the medication cart during medication passes, outside of the view of the nurse, and the physical therapy room was left unlocked and unattended with a hydroculator holding hot water.</p> <p>Findings include:</p>				<p>held bi-annually. The consulting pharmacist will provide med pass reviews monthly for three month and then quarterly. The ADON and DON will monitor. Ongoing monitoring for one year.</p> <p>Completed date: 07/14/11 Mandatory in-services will be held on July 5, July 6, July 7, and July 8, 2011, for all nursing employees regarding accidents and hazards – specifically leaving the physical therapy (PT) room unlocked and unattended. During the survey, a sign was placed on the door of the PT room that states, "Physical Therapy room must be locked if staff is not in attendance". The hydroculator has been moved to a secure and locked room within the physical therapy room. The key to the room is secure and out of reach of residents. A sign has also been placed on the door where the hydroculator is located that says, "This door must be locked at all times if staff is not in attendance". Mandatory in-services will be held on July 5, July 6, July 7, and July 8, 2011, for all nursing employees addressing the physical therapy room being unlocked and unattended with a hydroculator holding hot water inside. The charge nurse, ADON, and DON will monitor. Ongoing monitoring for one year.</p> <p>Completed date: 07/14/11 Mandatory in-services will be held on July 5, July 6, July 7, and July 8, 2011, for all nursing</p>		

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					<p>employees. The in-services address tab and pad alarms correct usage. Residents with alarms in place will be checked each shift for correct placement of alarm and alarm box. Alarm assessments will be completed quarterly and as needed. The charge nurse, ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 07/11/11 New side rail assessments were completed on all residents. A list of residents using side rails were placed in the CNA's charting book and the treatment book for reference. Side rail assessments will be completed on a quarterly basis, or with change of condition, and the care plan will be updated to reflect any change. This will be monitored weekly with the care plans. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 07/01/11 Mandatory in-services will be held on July 7 and July 8, 2011, addressing medication administration. The facility policy and procedure for medication administration will be in-serviced. Nurses and QMAs will be monitored daily for correct administration of medication for one month. Monitoring will continue twice weekly after the first month. New hires will be in-serviced during orientation and ongoing in-servicing will occur bi-annually. Consultant pharmacist will perform</p>		

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	<p>A1. Resident #30's clinical record was reviewed on 6/7/11 at 12:07 p.m. The resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, osteopenia, osteoarthritis, spinal stenosis, chronic obstructive pulmonary disease, and hypertension. The resident's most recent quarterly Minimum Data Set [MDS] assessment, dated 4/21/11, indicated the resident required extensive assistance of 1 for transfers and ambulation, and had not had falls since the last assessment. The resident's most recent Fall Risk assessment was dated 4/20/11 and indicated the resident was at high risk for falls. The resident's Side Rail Assessment, dated 4/21/11, indicated the resident expressed a desire to have the side rails raised for their own safety and/or comfort, had fluctuations in levels of consciousness or a cognitive deficit, had visual deficits, was unable to get out of bed safely, had a history of falls, used the side rails for positioning and support, had not attempted to climb over the side rails, had evidence the resident may have a desire or reason to get out of bed due to nocturnal toileting, and had medications</p>				<p>medication administration review monthly for three months and then quarterly. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 07/14/11</p>		

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	<p>that would require safety precautions, an antidepressant and diuretic.</p> <p>Resident #30's care plan for fall risk potential, dated 4/20/2011, indicated the resident's last documented fall was 01/15/11. Interventions included the following:</p> <p>"-May use mechanical lift for transfers when [resident] is unable to stand. Encourage [resident] to request assistance with transfers/ambulation. Utilize wheelchair for long-distance locomotion. allow [resident] to perform as much of task as able. Pad alarm in place to bed, chair and wheelchair to alert staff of attempts to ambulate/transfer unassisted.</p> <p>-Ensure [resident] is wearing appropriate non-slip footwear.</p> <p>-Transfer [resident] with gait belt and assist of 2 when she is able/willing to bear weight. Obtain labs per MD orders.</p> <p>-Ensure [resident's] area is free of clutter and that frequently used articles are within easy reach.</p> <p>-Ensure one side of [resident's] bed is up against the wall."</p> <p>Review of Resident #30's nurses' notes included, but was not limited to, the following:</p> <p>1/11/11 11:25 p.m. "Resident observed sitting upright on floor/closet/in room. [No] c/o [complaint of] discomfort.</p>						

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	<p>AROM [active range of motion] all extremities [without] difficulty. Assist of 2 [with] gait belt to standing position. Ambulated [with] i [one] assist, rolling walker to/from bathroom [without] c/o pain or discomfort. Alarm observed on resident's bed. Assisted resident back to bed. Alarm in place. Reminded to use call light prn [as needed] assist."</p> <p>1/11/11 11:30 p.m. "B/P [blood pressure] 128/64 T [temperature] 97.1 P [pulse] 88 R [respirations] 20 O2 [oxygen] sat [saturation] 95% on RA [room air]. Denies discomfort."</p> <p>1/12/11 1:15 a.m. "Heard noise in hallway near resident's room. Staff to area. Resident observed in hallway outside of her room, seated in her wheelchair. Rolling walker beside wheelchair. Observed resident's night gown to be on backwards, closure strings tied. Alarm observed on bed. Urine on floor. Assisted resident to/from bathroom, skin care provided, gripper socks [changed], floor dried...assisted back to bed. alarm put in place. Again reminded resident to leave alarm in place and to use call light PRN assist..."</p> <p>1/15/11 9:00 p.m. "Had been in bed about 15 minutes when she was found on the floor beside her bed."</p> <p>1/15/11 10:10 p.m. "Had been returned to bed [with] tabs alarm on as before. Now found on floor again. Had pulled blanket</p>						

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	<p>up straight on bed. Gown was on backwards. Tabs magnet was clipped to itself so that it would not sound."</p> <p>1/16/11 12:05 a.m. "Resident [up] in recliner by TV on Holy Family Unit as to be under watchful eyes. Tab alarm on (L) [left] side as usual clipped to gown. Second alarm clipped to (R) [right] side and pinned also, she is @ this time unaware of 2nd tab alarm."</p> <p>4/25/11 3-11 p.m. "Weekly Summary...Took tabs alarm off once without it sounding and sat on side of bed and was seen and toileted per staff..."</p> <p>6/4/11 7:15 p.m. "Resident now in recliner. Has sounded alarm X 4 getting up wanting to do things independently. Are monitoring closely."</p> <p>On 6/8/11 at 9:20 a.m., Resident #30 was observed to be seated in her recliner chair at the bedside. The tabs type alarm box was located on the arm of the chair to the right of the resident. The string was clipped to the resident's right shoulder. The alarm box was not attached to anything to stabilize it if the resident attempted to get up.</p> <p>Resident #30's side rails were measured, on 6/7/11 at 9:45 a.m. and gaps between the slats measured up to 7 and 3/8 inches.</p> <p>A2. On 6/7/11 at 9:30 a.m., Resident #12</p>						

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	<p>was observed to be in bed with the top half side rails in the up position. The gap between the vertical rails appeared to be too large. Measurements were taken of the gaps, on 6/7/11 at 9:45 a.m. The top half rails had a gap of 7 and 1/8 inches. Bottom half rails were in place on the bed, but not raised. The bottom rails had gaps of 7 and 3/8 inches.</p> <p>Resident #12's clinical record was reviewed on 6/7/11 at 10:10 a.m. The resident was admitted to the facility on 5/13/08. Diagnoses included, but were not limited to, the following: dementia, congestive heart failure, hypertension, dysphagia, hyperlipidemia, osteoarthritis, pacemaker, and macular degeneration. The resident's Fall Risk assessment, dated 5/13/11, indicated a score of 18, with 10 or greater being high risk for falls. The resident's Side Rail assessment, dated 5/19/11, indicated the resident was using top 1/2 rails, had made no attempts to climb over the side rails, and indicated the use of diuretics would require safety precautions. The physician's orders, signed 4/15/11, indicated an order for bilateral top 1/2 side rails as needed while in bed as an enabler.</p> <p>Resident #12's most recent quarterly Minimum Data Set [MDS] assessment, dated 5/19/11, indicated the resident</p>						

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	<p>required extensive assistance of two staff for transfers. The care plan, dated 5/17/11, indicated a mechanical lift was used as needed for transfers, when the resident could not bear weight. The assessment also indicated the resident had experienced falls since the last assessment, with no injury.</p> <p>A3. The clinical record of Resident #15 was reviewed on 06/07/11 at 3:15 P.M.</p> <p>Resident #15 was observed, on 06/06/11 at 9:50 A.M., lying in bed on her right side with bilateral top 1/2 rails in the up position.</p> <p>In an interview with the DoN, on 06/06/11 at 9:50 A.M., she indicated that Resident #15 was not interviewable and used 1/2 side rails when in bed.</p> <p>The April 2011 Physician's Recap order sheet indicated Resident #15 had diagnoses which included, but were not limited to, Alzheimer's Dementia and osteoporosis. The April 2011 Physician's Recap further indicated Resident #15 was to have "bilateral top 1/2 siderails [sic] as needed while in bed as an enabler...tabs alarm to bed and recliner to alert staff to res [resident] attempts to get up unassisted..."</p>						

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	<p>The Side Rail Assessment, dated 04/21/11, indicated "Side rails are indicated and serve as an enabler to promote independence."</p> <p>The DoN [Director of Nursing] provided a list, dated 06/07/11, of residents who were currently using side rails, on 06/07/11 at 2:00 P.M. The list included, but was not limited to, the name of Resident #15, with a typed notation which indicated Resident #15 "will assist if hands placed on side rail."</p> <p>The slats of the side rails on the bed of Resident #15 were observed, on 06/07/11 at 10:00 A.M., to be up to 7 and 3/8 inches in width.</p> <p>A4. During observation on 06/07/11 starting at 9:45 A.M. a review of all siderails in the facility was conducted. All resident beds were observed, and gaps between vertical slats in the side rails exceeded 4 and 3/4 inches, as much as 7 and 3/8 inches. The following additional resident beds had gaps exceeding 4 and 3/4 inches, putting the residents at risk for entrapment of body parts: Sampled Residents #41, #10, and #23 Supplemental sample Residents #14, #21, #22, #16, #42, #6, #19, #20, #5, #13, #18, #31, #7, #40, #2, #35, #1, #37, #11.</p>						

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	<p>A5. In an interview with the DoN [Director of Nursing] on 06/06/11 at 10:10 A.M., she indicated Resident #9 was not interviewable, had fallen in the last two weeks, and alarms were not effective as a fall prevention intervention.</p> <p>The clinical record of Resident # 9 was reviewed on 06/07/11 at 11:15 A.M.</p> <p>The May 2011 Physician's Recaps indicated Resident #9's diagnoses included, but were not limited to, chronic lower extremity pain, and "history of Subdural Hematoma." The record did not include when the subdural hematoma occurred. The Recaps further indicated, "up ad lib [at liberty]... bilateral 1/2 siderails [sic] as enablers."</p> <p>The most current MDS [Minimum Data Set Assessment], dated 04/14/11, indicated that Resident #9 required extensive assist of one for bed mobility and transfer and had experienced two falls since the last assessment.</p> <p>The most recent Side Rail Assessment, dated 04/14/11, included questions to be answered yes or no. The questions included, but were not limited to: "6. Does the resident have a history of falls? Yes...8. Does the resident use the side rails for positioning or support? No...11.</p>						

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	<p>Is there evidence (reason to believe) the resident has (or may have) a desire or reason to get out of bed? If YES, explain Nocturnal toileting...Yes." The assessment further indicated, "Side rails are indicated and serve as an enabler to promote independence."</p> <p>The most recent care plan, updated 04/19/2011, indicated a problem of, "...potential for falls: last documented falls: 03/04/11 [line struck through] 03/05/11 [line struck through] and a handwritten note indicated, 05/27/11. The care plan interventions were: "Ensure frequently used items are within [name of Resident #9] easy reach, encourage [name of resident #9],...ensure [name of Resident 39] to request assist with transfer/ambulation as needed,...ensure [name of Resident #9] has easy access to call light, ...ensure [name of Resident #9] is wearing appropriate, non-slip footwear, ensure [name of Resident #9] area is free of clutter, ...MD [Physician] to perform medication review and handwritten note dated 05/27/11 indicated, "CBC [Complete Blood Count-a lab test] , CMP [Complete Metabolic Profile- a lab test]." The care plan intervention list lacked documentation of additional interventions to prevent further falls.</p> <p>An additional problem, updated 04/14/11,</p>						

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	<p>for "...requires assistance for MOBILITY characterized by the following function: positioning, locomotion/ambulation related to following functions: forgetfulness and risk for falls." The interventions included, but were not limited to, "bilateral top half rails utilized when in bed as enabler."</p> <p>The Nurse's Notes, dated 12/10/10 at 8:45 P.M., indicated, "Summed [sic] to the room via a CNA; Found resident lying on a quilt parallel with lounge and head facing bathroom door..." The Nursing Notes lacked any documentation of interventions to prevent further falls.</p> <p>The Nurse's Notes dated 12/17/10 at 5:15 P.M., indicated, "Another residents [sic] family member notified [name of staff member] that the resident was on the floor. Neuro vascular [sic] checks were initiated as the resident has a one cm [centimeter] in diameter purple raised area just to the right of the posterior skull midline in parietal area." An additional Nurse's Note, on 05/17/10 at 8:00 P.M., indicated, "Found resident on the floor in the middle of the room on her right side....Grippy socks applied..."</p> <p>A Falls and Incidents Log for December 2010, provided by the DoN on 06/07/11 @ 2:00 P.M., included, but was not</p>						

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	<p>limited to, entries r/t [related to] Resident #9 which indicated: On 12/10/10 at 8:45 P.M., Resident #9, "unwitnessed; found on floor; ambulating in bedroom; wearing slipper with no tread; no aids in use; no alarms in use," and on 12/17/10 at 5:15 P.M., "Unwitnessed; found on floor; unknown cause; resident states she was hanging onto the recliner and it slipped; wearing shoes; no ambulation aids in use; no alarms in use; 1 cm [centimeter] bruise to (R) [right] side of head." On 12/17/10 at 8:00 P.M., Resident #9 experienced, "Unwitnessed; found on floor; unknown cause; resident does not remember what she was doing prior to fall; wearing knee-high nylons; no ambulation aids in use; no alarms in use."</p> <p>The Nurse's Notes, dated 01/08/11 at 7:00 P.M., indicated, "calling for help, found on floor by doorway entrance..." The Nurse's Notes and the care plan lacked any documentation of an intervention to prevent further falls.</p> <p>The Nurse's Notes, dated 1/31/11 at 7:00 P.M., indicated "Summoned to room per CNA-Resident was on the floor in a supine position...resident stated she was getting ready for bed and sitting on the edge of the bed and slipped to the floor. Resident was barefooted. Gripper socks were applied before standing..."</p>						

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	<p>A Falls and Incidents Log for January 2011, provided by the DoN on 06/07/11 at 2:00 P.M., included, but was not limited to, entries r/t [related to] Resident #9 which indicated Resident #9 experienced, "01/08/11 at 7:00 P.M. Unwitnessed; found on floor; lost balance, getting up from chair/wheelchair; wearing shoes; wheelchair in use." On 01/31/11 at 7:00 P.M., "Unwitnessed; found on floor; slipped off bed; changing clothes/other ADLs [activities of daily living]; bare feet; no ambulation aids in use; no alarms in use."</p> <p>The Nurse's Notes, dated 03/04/11 at 5:00 P.M., indicated, "...Disgrundled [sic] wanting someone with her on a 1:1. CNA keeps pushing her in the w/c [wheelchair] around and around the unit." Another Nurse's Note, dated 03/04/11 at 6:50 P.M., indicated, "Heard yelling from her room. Resident on the floor in front of the toilet..." The Nursing Notes and care plan lacked any documentation of an intervention to prevent further falls.</p> <p>The Nurse's Notes, dated 03/05/11 at 4:50 P.M., indicated, "CNA ...called me that [name of resident] called. Was on the floor with feet toward her bed sitting on the floor. [name of Resident] said that she slid out of bed which would have</p>				

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	<p>pointed her feet in opposite direction. She said she hit her head..." The Nurses's notes and care plan lacked any documentation that an intervention had been initiated to prevent further falls.</p> <p>A Falls and Incidents Log for March 2011, provided by the DoN on 06/07/11 at 2:00 P.M., included, but was not limited to, "03/04/11 at 6:50 P.M. "Unwitnessed; found on floor;transferring on/off toilet; wearing shoes; no ambulation aids in use," and 03/05/11 at 4:50 P.M., "Unwitnessed; found on floor; ambulating in bedroom; e\wearing shoes, wheelchair in use."</p> <p>The Nurse's Notes, dated 5/13/11 at 4:00 P.M., indicated, "Resident found sitting on floor on buttock's [sic] with feet straight out and back against her bed. When questioned resident said 'I just slid of the bed.' The nursing note and care plan lacked any interventions added to prevent further falls.</p> <p>The Nurse's Notes, dated 05/27/11 at 3:40 P.M., indicated, "Nurse called to room per volunteer and dietary emp [employee] Resident sitting on floor in front of recliner..." The notes and care plan lacked any documentation of an intervention to prevent further falls.</p>						

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	<p>A Falls and Incidents Log for May 2011, provided by the DoN on 06/07/11 at 2:00 P.M., included, but was not limited to, 5/13/11 at 4:00 P.M., "Unwitnessed; found on the floor; slipped while sitting on the side of the bed; wearing shoes; wheelchair in use; half length top side rails up as enabler; alarm not in use," and "05/27/11 at 3:40 P.M. Unwitnessed; found on the floor; states slid out of recliner onto floor; wear plain socks; no ambulation aids in use; no alarms in use."</p> <p>In an interview with the DoN, on 06/07/11 at 1:00 P.M., she indicated she would not be able to provide documentation of specific interventions for each fall. She further indicted she would check the lab book to see if labs were done, but if they were not there, she would not be able to provide documentation of interventions.</p> <p>A Care Plan for falls was provided by the DoN on 06/07/11 at 2:00 P.M. The care plan, dated 04/14/11, indicated a problem of "potential for fall" with interventions including, but not limited to, "ensure items are within ...easy reach, encourage ...to request assist with transfer/ambulation as need -5/13 fall, ensure ...has easy access to call light, ensure...is wearing appropriate, no-slip frequently used footwear, ensure ...area is free of clutter, MD to perform medication</p>						

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	<p>review, 5-27-11 CBC [complete blood count] , CMP [complete metabolic panel]."</p> <p>On 06/07/11 at 2:00 P.M., the DoN provided a timeline for the fall interventions for Resident #9. The timeline indicated, "For falls 3/4/11 and 3/5/11, med [medication] review. Ativan was decreased from 0.5 mg to .25 mg at 5 P.M. On 03/08/11/ [sic] For Fall 5-13-11, encourage [name of resident] to request assist with transfers/ambulation. See Care plan dated 05/16/11. For Fall 5-27-11. CBC. CMP."</p> <p>The DoN [Director of Nursing] provided a list, dated 06/07/11, of residents who were currently using side rails on 06/07/11 at 2:00 P.M. The list included, but was not limited to, the name of Resident #9.</p> <p>A6. Resident #28's clinical record was reviewed on 6/7/11 at 3:25 p.m. The resident was admitted to the facility on 2/10/09 with diagnoses including, but not limited to, Alzheimer's Disease and osteoporosis. The resident's last full Minimum Data Set [MDS] assessment, a significant change assessment, was dated 3/17/11. The assessment indicated the resident required total assistance of two staff for transfers, and was unable to</p>						

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	<p>ambulate. The assessment indicated he had falls since the previous assessment, with no injury. The assessment indicated he utilized bed rails.</p> <p>Resident #28's Side Rail Assessment, dated 3/17/11, indicated the resident had fluctuations in levels of consciousness or a cognitive deficit related to a dementia diagnosis, had visual deficits, was able to get in/out of bed, was not able to get out of bed safely, had a history of falls, used the side rail to help rise from a supine position to a sitting/standing position, had not attempted to climb over the side rails, and there was evidence the resident had a desire or reason to get out of bed, nocturnal toileting. The recommendations were for top half rails to serve as an enabler to promote independence.</p> <p>The resident's Personal Alarm Assessment was dated 3/17/11. It indicated the date of the last fall as 1/18/11 and a history of previous falls. The assessment failed to indicate "unsafe behaviors" of trying to stand, transfer or walk alone, or trying to get out of bed unsafely. The assessment did indicate problems with walking, transfers, toileting, communication, and cognitive ability. The determination was for the resident to have a tab alarm at all times.</p>						

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	<p>Resident #28's care plan was reviewed on 3/22/11. The care plan for mobility, dated 3/16/11, indicated a mechanical lift was to be used for the resident's transfers.</p> <p>Resident #28 had a care plan as follows: "[Resident's name] is a fall risk related to: dementia diagnosis, physical limitations and urinary incontinence. Last documented fall: 1/18/2011."</p> <p>Interventions included the following: "-Tabs/pad alarm to alert staff of attempts to ambulate/transfer unassisted. Place tabs alarm and clip out of [resident's] reach to ensure proper utilization. Quarterly assessment to determine need for continued alarm use. -Provide [resident] staff assist with transfers/toileting. -Ensure [resident] is wearing appropriate, non-slip footwear. -Ensure that [resident's] frequently used items are within easy reach."</p> <p>Review of Resident #28's nurses' notes included, but was not limited to, the following: 1/18/11 10 p.m. "CNAs make rounds found resident laying half way on the floor and bed. Resident on stomach [with] head turned to (R) [right] side and laying on his arm. (L) [left] leg on floor [with] (R) leg still on the bed, on pad alarm. Able to move all extremities. Has red places on (R) forehead, cheek and (R)</p>						

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	shoulder. Assisted up [with] gait belt and iii [three] staff members. At that time, when (R) leg was removed from bed, alarm went off. Resident bed was in lowest position had on gripper socks and alarm working properly." The note was written by a Qualified Medication Assistant [QMA]. 1/18/11 10:15 p.m. "B/P [blood pressure] 156/90 P [pulse] 70 R [respirations] 20 T [temperature] 98.3 02 [oxygen] sat [saturation] 95% on RA [room air]. Sr. [Sister] [name of nun supervisor] notified, message left on answering for POA [power of attorney]." QMA note. 1/18/11 10:50 p.m. "Dr. [name's] office fax regarding fall on resident." QMA note 1/19/11 12:00 a.m. "Neuro [checks] WNL [within normal limits] B/P 148/80 T. 97.5 P 68 R 18 02 sat: 95% on RA. Resident awakens easily, Denies discomfort..." 2/4/11 11-7 "Resident observed attempting to get out of bed unassisted several times early this shift. Denies discomfort. Care provided, fluids offered...Alarm remains in place." 3/15/11 11:30 p.m. "Resident observed awake, in bed [with] legs off the side of bed. Alarm in place. repositioned back to bed." 4/15/11 3-11 p.m. "A little restless @ beginning of shift, trying to climb out of recliner in his room. CNAs assist [with] Hoyer lift to get resident up. Toileted and						

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	<p>put in his wheelchair. Much calmer. Sitting in common area watching T.V..." 4/19/11 11:45 p.m. "Resident observed [with] legs off side of bed. Assisted [with] placing legs back on bed...alarm in place." 5/1/11 11-7. "Resident has been observed attempting to get out of bed @ X's [times] this shift. Legs off side of bed, assisted back to bed. Denies discomfort. Alarm remains in place." 5/4/11 9:30 p.m. "Tab alarm set off found res. [resident's] lower body on (R) knee on floor - upper body in bed. (R) knee reddened no other bruises or O/A [open areas] observed. Assist back to bed tab alarm on. B/P 140/78 T 98.8 P 93 R 20 02 Sat 95% room air. Has been more confused though." 5/4/11 10:15 p.m. "CNA observed resident starting to put legs over side of bed again. Assist back to bed. Tab alarm in place." 5/4/11 10:40 p.m. "Dr. [name] notified fax and Sr. [name of nun supervisor] notified." 5/4/11 11:00 p.m. "Resident trying to climb out of bed again." 5/10/11 3-11 p.m. "...Once in bed, tried X 3 to get out of bed. Alarm in place and working properly." 5/16/11 8:30 p.m. "Found resident on the floor; sitting [with] back up against the bed. Leaning to the (R) [with] head</p>						

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	<p>pressing against side rail. Bed in low position. TAB monitor on and did not engage. ROM [range of motion] adeq. [adequate] to all extremities..."</p> <p>5/17/11 9:30 p.m. "Attempting to climb out of bed X 2. Set tabs monitor off. Wanting to go fishing..."</p> <p>6/4/11 2:45 a.m. "During routine bed check, resident observed sitting upright on floor beside bed. Bed in lowest position. Alarm still attached, did not pull away to sound. AROM [active range of motion] all extremities [without] difficulty. Denies discomfort. B/P 124/70 T 98 P 76 R 18 O2 sat: 96% RA. Assisted to standing position per (3) assist and gait belt. Assisted to bed. [No] redness noted of buttocks or back. Alarm positioned to opposite side of bed and attached to resident's night shirt. Encouraged call light use."</p> <p>The Immediate Jeopardy began on 6/7/11, when side rails were observed to have gaps between the vertical slats that measured greater than 4 and 3/4 inches, with potential for head/neck/or limb entrapment. The Administrator, DoN and President of the facility were made aware of the Immediate Jeopardy on 6/7/11 at 2:00 p.m., related to side rails having gaps between slats greater than 4 and 3/4 inches, with potential for entrapment and related to repeated falls for residents at</p>						

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	<p>risk for falls without revision of interventions to deal with the falls. The IJ was removed on 6/11/11, when through observation, interview and record review , it was determined that the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem.</p> <p>Observation of side rail gaps being covered so that entrapment could not occur, review of order confirmation of manufacturer kits to fix the side rail gaps, review of records for appropriate side rail assessments, fall risk assessments, and revision in interventions for fall prevention, indicated the facility had removed the immediacy of the problem. Even though the facility's corrective action removed the IJ, the facility remained out of compliance at a reduced scope and severity level of pattern no actual harm with the potential for more than minimal harm.</p> <p>B1. On 6/8/11 at 12:55 p.m., RN #1 was observed during a medication pass on the St. Joseph Unit. The medication cart was observed to have a plastic container with several cup type holes. The RN had medication cups set up in the holes with unit dose packaged medications in the cups, set up with resident names in front of each cup. During interview at that</p>						

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	<p>time, she indicated they were the medications she was preparing to give.</p> <p>RN #1 entered Resident #24's room to administer medications at 1:00 p.m. The medication cart was left in the hallway, out of sight of the RN, with the medications on top of the cart.</p> <p>RN #1 was observed entering Resident #41's room to administer medications at 1:02 p.m. She was out of sight of the medication cart, with medications setting on top of the cart.</p> <p>RN #1 was observed entering Resident #30's room at 1:04 p.m. The medication cart was out of sight of the RN, with medications on top of the cart.</p> <p>B2. On 6/10/11 at 10:10 a.m., during the general environment tour with the Administrator, the following was observed in the soiled utility room on St. Joseph Unit, in a cabinet under the sink, which was unlocked and unattended: -a plastic squirt bottle with a green liquid, hand written on the bottle was "Odoban." During an interview at that time, the Administrator indicated it must be an air deodorizer. During an interview at that time, the Housekeeping Supervisor indicated, at 11:40 a.m., the company would not send labels for the smaller</p>						

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	<p>bottles and indicated for them to write the product name on the bottle with permanent marker. The label was available on the larger bottles. A label was observed at 11:50 a.m. and indicated contact should be avoided with eyes, skin or clothing. First aid for ingestion was to call the physician or poison control center, drink 1 or 2 glasses of water.</p> <p>-a bottle of Mikro-quat, a sanitizing solution, which was hooked to the sink with tubing, labeled causes respirator tract, digestive tract, eye and skin burns. Harmful if swallowed.</p> <p>-a can of Glade Hawaiian breeze, labeled "Keep out of reach of children."</p> <p>-a spray can of "Hot Shot" Roach and Ant spray, labeled "If swallowed, immediately call poison control."</p> <p>B3. On 6/10/11 at 11:10 a.m., the Therapy room, located on the first floor across from the chapel, was unlocked and unattended. No residents were in the vicinity. A hydroculator [a device used to keep hot packs hot], was in the room, turned on, and full of water and hot packs. The hydroculator had a lid on it with a handle and easily opened. The water temperature inside was measured at 166 degrees Fahrenheit. Residents on all three units would have access.</p> <p>The Director of Nurses indicated, during</p>						

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	<p>interview at 11:15 a.m., the Physical Therapist had just left a few minutes prior and usually locked the door. The door was locked at that time. The Director of Nurses indicated they did have residents with cognitive impairment, but "no active wanderers" at the current time.</p> <p>B4. Review of the Resident Roster, provided by the Director of Nurses on 6/6/11 at 12:30 p.m., 30 of the 42 residents were documented as having cognitive impairment.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>						

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F0327 SS=D	<p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 3 sampled residents reviewed for hydration, in the sample of 11, was provided with sufficient fluids, in that fluids were not always offered when contact with the resident, and sufficient water was not offered with medications. (Resident #41)</p> <p>Finding includes:</p> <p>Resident #41's clinical record was reviewed on 6/6/11 at 2:35 p.m. The resident was admitted to the facility on 4/14/04. Diagnoses included, but were not limited to, Glaucoma, osteoporosis, atherosclerosis, chronic kidney disease, macular degeneration, hypertension, congestive heart failure, anxiety and depression. The resident's medication orders, signed 5/19/11, included, but were not limited to, Demadex [diuretic].</p> <p>The resident's care plan, dated 4/13/11, had a focus/problem of "[Resident's name] has the potential for alteration in fluid maintenance: occasional edema, PO [oral] diuretic med use and diagnoses of CHF [congestive heart failure], pulmonary edema and renal</p>		F0327	<p>Mandatory in-services were held on June 23, June 24, June 27, and will be held on July 1, 2011, addressing adequate hydration in the elderly. Ways to prevent dehydration, and offering sufficient water with medications. All care plans have been reviewed and updated that address hydration with specific interventions. Resident # 41 was placed on I and O to further monitor fluid consumption. Ongoing in-services will be held bi-annually to review hydration specifics. All residents will be assessed for signs and symptoms of dehydration and interventions will be initiated if needed. Residents will be assessed weekly for signs and symptoms of dehydration and documented in a weekly summary. The ADON and DON will monitor. Ongoing monitoring for one year.</p>		07/14/2011	

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	<p>insufficiency." Interventions included the following:</p> <p>"-Give [resident's name] Demadex 40 mg [milligrams] PO daily, obtain labs per MD orders, provide prescribed diet (mech soft), monitor for signs and symptoms of fluid deficit/overload (tenting skin, edema, dry mouth, increase/decrease in urinary output etc.).</p> <p>-Give [resident's name] KCL [potassium chloride] 10 meq [milliequivalents] PO daily."</p> <p>The most recent laboratory reports were dated 5/5/11. The resident's Blood Urea Nitrogen [BUN] was elevated at 44, with normal ranges of 7 to 18. The resident's Creatinine was slightly elevated at 1.3, with normal range from 0.6 to 1.1.</p> <p>Resident #41 was observed, during the initial tour, on 6/6/11 at 9:50 a.m., to be seated in a recliner chair in her room, mumbling. She had an 8 ounce Styrofoam cup of water at a table beside her. She had hand rolls in both hands as an anti-contracture intervention. In an interview at that time, the Director of Nurses indicated the resident was followed on their nutrition at risk program and had lost weight and was receiving supplements.</p> <p>Resident #41 was observed on 6/7/11 at</p>						

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	<p>8:40 a.m. to be in her recliner chair again. CNA #3 was observed in the room with the resident. The CNA offered to toilet the resident. CNA #5 and CNA #3 assisted the resident to the bathroom and back to the recliner chair. No fluids were observed offered to the resident.</p> <p>On 6/8/11 at 6:30 p.m., Resident #41 was observed in the small dining room. She had been fed her evening meal. A six ounce cup of apple juice was in front of the resident. Three [3] ounces were left.</p> <p>On 6/9/11 at 8:50 a.m., RN #1 was observed to administer medications to Resident #41. She administered oral medications with a nutritional supplement, eight ounces. She brought in 4 ounces of water, gave the resident one ounce and then threw the rest out.</p> <p>On 6/9/11 at 12:20 p.m., Resident #41 was in the small dining room with her lunch tray. A six ounce cup of water, with three ounces remaining, was observed.</p> <p>On 6/9/11 at 2:25 p.m., RN #1 was interviewed. She indicated, on her unit, the only resident being monitored for intake and output was the resident with a tube feeding (Resident #12). They were not monitoring Resident #41 for intake and output.</p>						

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F0332 SS=E	<p>3.1-46(b)</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having 9 medication errors out of 50 opportunities for error, resulting in an 18% error rate. This affected 3 of 12 residents observed for medication pass (Residents #12, #27, #41), and 3 of 4 nurses observed to pass medications. (RN #1, RN #2, LPN #1)</p> <p>Findings include:</p> <p>1. During an observation of the medication pass, on 06/08/11 at 12:00 P.M., RN #1 indicated she was preparing to administer medications and through a g-tube. RN #1 prepared MAPAP</p>			F0332	<p>Mandatory in-services will be held on July 7 and July 8, 2011, addressing medication administration, correct time of medications, and omissions of medications. The facility policy and procedure for medication administration will be in-serviced. Nurses and QMAs will be monitored daily for one month for correct administration of medication. Monitoring will continue twice weekly after the first month. New hires will be in-serviced during orientation, and ongoing in-servicing will occur bi-annually. Consultant pharmacist will perform medication administration review monthly for three months and then quarterly. The ADON and DON will monitor. Ongoing monitoring for one year.</p>		07/14/2011

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	<p>[Tylenol, medication for pain] 20 ml [650 mg] and placed in a medication cup. RN #1 was observed to obtain 30 cc [cubic centimeters] of water and place on a small plastic tray for transport to the resident's room.</p> <p>Resident #12 was observed lying in bed with the head of bed elevated approximately 30 degrees, on 06/08/11 at 12:00 P.M.</p> <p>RN #1 entered the room of Resident #12 and set the small tray of prepared medication and water flush on the bedside cabinet.</p> <p>RN #1 was then observed to install a 30 cc [cubic centimeter] air bolus to the open port of the g-tube. RN #1 was then observed to remove the stethoscope from around her neck and apply the bell of the stethoscope to the resident's abdomen.</p> <p>During an interview, at that time, RN#1 indicated, "Oh, I heard sounds."</p> <p>RN #1 was then observed to apply gloves and pull Jevity up in a 60 cc syringe. RN #1 then released the Jevity back into the cup, wiped the tip of the syringe with a Kleenex, and inserted the tip of the 60 cc syringe into the open port of the tube.</p>				<p>Completed date: 07/14/11 New Policy and Procedures were adopted regarding tube feeding and medication administration with G-tubes. Mandatory in-services were held on June 23, June 24, June 27, and will be held on July 1, 2011, to review the new policies. All nurses and QMAs will have given a return demonstration of tube feeding and medication administration by the completion date. Any new hires will be in-serviced during their orientation. Ongoing in-services will occur quarterly. Nurses and QMAs will be observed one time daily for one month, and then they will be observed weekly for correct administering of tube feeding and medication administration through G-tubes. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 07/08/11</p>		

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	<p>RN #1 then indicated, "I don't know why I am getting so nervous after so many years."</p> <p>RN #1 was then observed to administer MAPAP 20 ml [equals 650 milligrams] via g-tube without performing a flush after the feeding and before medication administration. RN #1 was then observed to fill the open syringe attached to the g-tube with 30 cc water. At that time, the tube and the open syringe disengaged, spilling water and MAPAP onto the abdomen of Resident #12.</p> <p>In an interview, at that time, RN #1 indicated, "That has never happened to me in all my years of nursing."</p> <p>The Clinical Record of Resident #12 was reviewed on 06/07/11 at 10:10 A.M.</p> <p>The April Physician's Order Recap included, but was not limited to, orders for "Acetaminophen 160 mg/ml [milliliter] per g-tube every 8 hours, check for residual prior to each fdg [feeding] notify MD [physician] if > [greater than] 200 cc, Jevity 1.0-237 ml (1 can) via g-tube 5X's [times] daily, flush g-tube w/ [with] 30 cc H2O [water] and 45 cc Gatorade after each feeding/med pass."</p> <p>The failure to check placement, the failure</p>						

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	<p>to flush the tube before and after the medication administration, and the failure to administer all the Tylenol to the resident, resulted in three [3] medication errors for this observation.</p> <p>On 6/8/11 at 5:50 p.m., RN #2 was observed administering medications through a gastrostomy tube to Resident #12. The medications included, but were not limited to, Ranitidine [medication to reduce stomach acid] 150 mg [milligrams]. She crushed the medication and mixed it and one other medication with 10 cc [cubic centimeters] of water. She mixed a third medication with 10 cc of water. She then placed another 10-15 cc of water in a medication cup. She indicated, "that will make the 30 cc flush." She then poured up 45 cc of Gatorade. Everything was placed on a small plastic tray and taken to Resident #12's bedside.</p> <p>RN #2 then took the plug out of the gastrostomy tube and attached a syringe to the tube. She pulled back on the plunger and nothing entered the chamber of the syringe. She disconnected the syringe and stated, "usually don't get anything back, maybe a dribble." She proceeded to remove the plunger from the syringe and attach the syringe to the tube and was preparing to pour the medications into the</p>						

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	<p>tube. At that point, she was stopped and questioned if she was able to be sure the tube was in the stomach, since there was no residual. She indicated she guessed she couldn't be sure. She then left the room and obtained a stethoscope, injected air into the tube and listened with the stethoscope to see if the air entered the stomach.</p> <p>After checking placement of the tube, the RN immediately poured the 10 cc of water with the two crushed medications into the chamber of the syringe. No flush was done prior to the administration. She then administered the one medication in the 10 cc of water. When some residual medication was observed in the medication cups, she poured Jevity 1.2 feeding solution from the can into the cups and poured that into the syringe. She proceeded to pour the rest of the can of Jevity 1.2 into the chamber and let it drain into the stomach by gravity. She followed the feeding with the Gatorade, and then 10-15 cc of water in the medication cup. She then removed the syringe and plugged the tube.</p> <p>Resident #12's physician's orders were checked on 6/9/11 at 10:25 a.m. The physician's orders for medications, signed on 4/15/11, included, but were not limited to, the following:</p>						

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	<p>"Ranitidine 150 mg tablet take 1 tablet per G-tube at bedtime."</p> <p>"Artificial tears drops instill 2 drops into each eye twice daily."</p> <p>The Medication Administration Record was reviewed, at the same time, and indicated the Ranitidine was scheduled for 9:00 p.m. and the Artificial tears were scheduled for 5:00 p.m.</p> <p>The failure to check placement, the failure to flush the tube before and after medications, the Ranitidine given at the wrong time, and the Artificial Tears omission, resulted in 4 errors during this observation.</p> <p>The Policy and Procedure for Medication-Feeding Tube dated 07/2005, provided by the DoN [Director of Nursing] on 06/09/11 at 1:45 P.M. indicated, "6. Attach syringe to end of the tube and insert twenty (20) cc of air. a. Check placement and patency by auscultation. [listening for air sounds with the bell of a stethoscope over the abdomen]...7. Insert medication by syringe slowly into tube...8. Flush with thirty (30) cc of water..."</p> <p>The Geriatric Medication Handbook, Eighth Edition, reviewed on 6/9/11 at 2:00 p.m., indicated the following: "Medication administration via enteral</p>						

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	<p>tubes procedures: ...8. Check for proper tube placement...12. Put 15-30 ml [milliliters] water in syringe and flush tubing using gravity flow...13. Pour dissolved/diluted medication in syringe...14. Flush tubing with 15-30 ml of water, or prescribed amount..."</p> <p>During an interview with the DoN on 06/10/11 at 12:20 P.M., she indicated If the nurses had questions about g-tubes they would ask her and she would look on the internet. At that time, the DoN indicated, the resources that she had in the facility were from 1980 and 1987.</p> <p>2. During the morning medication pass, on 06/08/11 at 9:10 A.M., LPN #1 was observed to prepare and administer medications for Resident #27. The medications LPN #1 administered included, but were not limited to, Folic Acid 1 mg [milligram] [a vitamin supplement] and Calcium 600 with Vitamin D [a supplement].</p> <p>Resident #27 was observed, on 06/08/11 at 9:10 A.M., sitting at a table playing cards.</p> <p>In an interview with Resident #27, on 06/08/11 at 9:10 A.M., she indicated, "I had breakfast already and it was good."</p> <p>The Clinical Record of Resident #27 was</p>						

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	<p>reviewed on 06/08/11 at 11:00 A.M. The May 2011 Physician's Recap indicated, "Folic Acid 1 mg [milligram] tablet take (1) tablet by mouth once daily with breakfast for nutritional supplement...Calcium 600 W/D [with Vitamin D] tablet Take 1 tablet by mouth twice daily with meals..."</p> <p>A document supplied by the DoN [Director of Nursing], on 06/06/11 at 12:30 P.M., indicated breakfast was served at 8:00 A.M.</p> <p>In an interview with DoN, on 06/09/11 at 3:00 P.M., she indicated, "We can't give meds with meals, we aren't allowed to pass meds in the dining room."</p> <p>A policy and procedure for Medication Administration, dated 07/2005, was provided by the DoN on 06/13/11 at 12:10 P.M.; it indicated, "8...b. Read and follow any special instructions written on labels..."</p> <p>3. On 6/9/11 at 8:50 a.m., RN #1 was observed administering medications to Resident #41. The medications included, but were not limited to, KCL [potassium Chloride] 10 meq [milliequivalents] one tablet. The RN was observed to administer 13 and 1/2 pills, including the KCL, to the resident, two at a time followed by sips of a nutritional</p>						

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	<p>supplement. The last one pill was given with one ounce of water, from four ounces in a cup. The additional 3 ounces were thrown out.</p> <p>The resident's clinical record was reviewed on 6/6/11 at 2:35 p.m. The physician's orders, signed on 5/19/11, included, but were not limited to, an order for KCL 10 meq po [by mouth] twice daily.</p> <p>The 2010 Nursing Spectrum Drug Handbook, reviewed on 6/9/11 at 10:30 a.m., indicated the following regarding potassium chloride: "Give P.O. form with meals and a full glass of water or juice, to minimize GI [gastrointestinal] upset."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>						

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure food was stored, prepared, and served under sanitary conditions, in that outdated foods were found in the freezer, and hands were not washed/gloves changed between soiled activities and clean activities, for 1 of 1 kitchen observation, and 1 of 3 meal service observations (Evening meal 6/8/11). This deficient practice had the potential to affect 41 of 42 residents in the facility who ate meals from the kitchen.</p> <p>Findings include:</p> <p>1. During observation in the kitchen on 6/9/11 at 11:45 a.m., Volunteer #1 was observed in the peeling room, peeling potatoes. He was wearing blue disposable gloves. He was observed to handle the rim of the trash can with the gloved hands and then proceed to peel potatoes.</p> <p>During the same observation in the kitchen, on 6/9/11 at 11:45 a.m., walk-in freezer #1 was observed. There was ice on the floor at the threshold. Four fans at the back of the freezer had accumulated ice on them. There were four stacks of</p>			F0371	<p>Mandatory in-service was held on June 24, and June 27, 2011 for all dietary employees. Dietary staff was in-serviced on the preparation, storage, and serving of food. The facility has a policy and procedure on reception and use of food items. Inventory will be maintained on receipt and usage dates. Designated employees have been in-serviced, on "first-in, first-out" procedure. Older food items will be monitored weekly when the main food order arrives. Older food items will be moved to the front and items nearing their expiration date, or food items that appear to be close to expiration regardless of the date, will be relocated to a designated rack for immediate usage or disposal.</p> <p>The dietary manager, or designate, will make the decision on whether the food item will be used or disposed. Donated food will be transported in an air conditioned van. A cooler with freezer ice packs will be used if needed. Mandatory in-service will be held on July 5 and July 7, 2011, for all dietary employees. A new policy and procedure regarding handwashing and gloves will be instituted. Dietary staff will be in-serviced on the</p>		07/07/2011

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	<p>boxes setting directly on the floor. Packages of store bought boneless chicken breasts were observed in a plastic bin on a shelf. The label indicated they were to be used or frozen by 12/8/10. There was a plastic container with whole frozen green, yellow, and red peppers, loosely covered with foil. There was no label on the container. There was another plastic container with whole peppers, loosely covered with foil, with a label dated 6/26/10.</p> <p>The Dietary Service Manager [DSM] was interviewed, on 6/9/11 at 2:48 p.m. She indicated she had submitted maintenance orders for the ice build-up in the freezers a couple days ago. She indicated the facility received a lot of donated foods from businesses; a nun and another employee routinely went to the businesses and collected the donations. She indicated she did not have a written policy on how to handle the donated food, i.e. how it was transported and what to save and what to discard. She indicated she didn't have a food storage policy, but the items with dates 12/10 and 6/10 should have been discarded.</p> <p>2. During the observation of the evening meal, on 06/08/11 beginning at 6:00 P.M., three staff members were observed wearing gloves while delivering meals from the buffet in the dining room.</p>				<p>new handwashing and glove policy and procedure. Dietary staff will also be required to complete a post in-service test. During the survey, ice build up in the freezer was noted. An outside refrigeration contractor was called and he evaluated the freezer and the problem of ice build up. Parts had to be ordered. The contractor has stated he will return on July 1, 2011 to make the repair. Ongoing monitoring for one year.</p>		

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	<p>Dietary Employee #1 was observed to apply gloves, retrieve a meal tray from the buffet line and deliver it to a random resident. Dietary Employee #1 was then observed to return to the tray line, wipe her gloved hands on her uniform, retrieve another tray, and deliver it to another random resident. Dietary Employee #1 was not observed at any time to remove her gloves and perform hand hygiene.</p> <p>Dietary Employee #2 was observed to apply gloves, retrieve a meal tray from the buffet line and deliver it to a random resident. Dietary Employee #2 was then observed to return to the tray line, wipe her forehead with a gloved hand, retrieve another tray, and deliver it to another random resident. Dietary Employee #2 was not observed at any time to remove her gloves and perform hand hygiene.</p> <p>QMA #2 was observed to apply gloves, retrieve a meal tray from the buffet line and deliver it to a random resident. QMA #2 was then observed to return to the tray line, touch multiple residents' wheelchair handles and personal clothing, retrieve another tray, and deliver it to another random resident. QMA #1 was not observed at any time to remove her gloves and perform hand hygiene.</p>						

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F0425 SS=E	<p>In an interview with the Certified Dietary Manager [CDM], on 06/08/11 at 6:30 P.M., she indicated, "We wear gloves to pass out trays."</p> <p>In an interview with the DoN, on 06/13/11 at 2:00 P.M., she indicated, "We do not have a policy on gloves."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>						
	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on observation, interview and record review, the facility failed to ensure pharmacy services and pharmacist</p>			F0425	<p>The facility adopted a new glucometer disinfectant policy. During the survey process each resident who had orders for</p>		07/14/2011

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	<p>consultation to ensure residents received medications and medication monitoring in accordance with their needs and accepted practices, for 1 of 1 sampled resident who required blood glucose checks (resident #10), in the sample of 11, and 9 of 9 supplemental sample residents requiring blood glucose checks (residents' #5, #2, #40, #38, #39, #4, #36, #32, #21), in the supplemental sample of 29. The facility failed to ensure opened medications were dated when opened, and expired treatment supplies were discarded, for 2 of 3 facility units observed (Holy Family unit, Jeanne Jugan unit). This deficient practice had the potential to affect 27 of 27 residents residing on those two units.</p> <p>Findings include:</p> <p>1. The medication pass observation began on 06/08/11 at 11:35 A.M.</p> <p>QMA #1 was observed to retrieve a glucometer from the medication cart, obtain 3 alcohol pads, and 1 lancet strip and place these supplies on a blue tray. QMA #1 was then observed to take the supplies on the tray into the Room of Resident #5. QMA #1 was then observed to place the tray on the bed of Resident #5, enter the bathroom of Resident #5 and perform handwashing for 10 seconds. QMA #1 was then observed to apply</p>				<p>accuchecks were given their own individual glucometer. Nurses and QMAs were in-serviced on June 23, June 24, June 27, and will be in-serviced on July 1, 2011, addressing glucose testing and glucometer disinfecting. New hires will be in-serviced during orientation process on glucometer testing and glucometer disinfecting. Ongoing in-services will occur bi-annually. Nurses and QMAs will be monitored twice weekly regarding glucometer sanitation. Consulting pharmacist has reviewed the policy on glucometer testing and disinfecting and will monitor staff monthly on performance of disinfecting glucometer. The ADON and DON will monitor. Ongoing monitoring for one year.</p> <p>Completed date: 07/08/11</p> <p>In-services will be held on July 7 and July 8, 2011 for nurses and QMAs addressing dating medication bottles when opened and monitoring for expired drugs and treatments. The policy for medication in storage in the facility will be in-serviced. Pharmacy technicians audited all medication carts, treatment carts, and medication storage areas for expired drugs. Consultant pharmacist will monitor medication storage areas monthly for expired drugs and treatments. Pharmacy technicians will audit medication carts every two months for expired drugs. The consultant pharmacist reviewed</p>		

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	<p>gloves and wipe the glucometer with an alcohol pad. QMA #1 was then observed to wipe the finger of Resident #5 with an alcohol prep pad and perform a fingerstick on Resident #9 without changing her gloves or performing hand hygiene. QMA #1 was then observed to touch the test strip to the finger of Resident #5 to obtain a drop of blood. QMA #5 was then observed to insert the test strip into an Optium EZ glucometer [a machine to check blood sugar].</p> <p>In an interview at that time QMA #1 indicated, "Her Accucheck is 101."</p> <p>QMA #1 was then observed to remove her gloves and perform handwashing for 10 seconds. QMA #1 was then observed to wipe the glucometer with an alcohol pad and return it to the medication cart.</p> <p>In an interview with QMA #1 at that time she indicated, "There are two Accuchecks on this floor, [name of Resident #5 and name of Resident # 40]. There is one glucometer for every unit, they [Resident #5 and Resident #40] share...The next Accucheck is at 5:30 P.M."</p> <p>During an interview at that time with QMA #1, when asked about the sanitizing protocol she indicated "We are supposed to clean it with alcohol each time we use</p>				<p>the policy and procedure for medication storage in the facility and consultant pharmacist services provider requirements. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 07/14/11</p>		

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	<p>it."</p> <p>In an interview with the DoN on 06/08/11 at 5:00 P.M. she indicated, "We did not inservice on the Optium EZ [the glucometer that was used by QMA #1], it is just like the old one, we just don't have to reprogram like before."</p> <p>2. On 6/8/11 at 11:35 a.m., LPN #2 was observed using a glucometer from the medication cart to check Resident #36's blood sugar. Upon completion of the procedure, she took an alcohol wipe and thoroughly wiped off the glucometer machine.</p> <p>On 6/8/11 at 12:03 p.m., LPN #2 was interviewed. She indicated she had no more blood glucoses to check. When queried about using alcohol swabs to disinfect the glucometer, she indicated that was what they were taught to use. At the same time, a policy and procedure was observed posted on the medication room cabinet door. The policy indicated the facility was to disinfect the glucometers between residents with 70% alcohol swabs.</p> <p>At 12:05 p.m. on 6/8/11, the Director of Nurses [DoN] was interviewed. She indicated the facility had been cited on the previous annual survey for not sanitizing</p>						

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	<p>glucometers between residents. She indicated she had written the policy at that time and used their glucometer manufacturer's instructions to develop the policy.</p> <p>At 1:00 p.m. on 6/8/11, the DoN provided a copy of the cleaning instructions for the facility's model and brand of glucometer. The instructions were as follows: "Cleaning Your Monitor Store your monitor in its carrying case. If the surface of your monitor gets dirty, you may clean it. Use a damp cloth and mild soap. Healthcare professionals: Acceptable cleaning solutions include 10% Bleach, 70% Alcohol, or 10% Ammonia."</p> <p>On 6/9/11 at 9:30 a.m., the DoN was interviewed. At that time, she provided the manual for the facility's glucometer. It indicated it was appropriate to use in healthcare settings for more than one person. The DoN indicated she had called the manufacturer and they had indicated the facility should follow the instructions in the manual for cleaning. The DoN indicated checked the Centers for Disease Control [CDC] web site and was unable to find information. She then indicated she called the CDC and spoke to a representative. She was told to follow the manufacturer's recommendations. She</p>						

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	<p>indicated when she informed the CDC representative the instructions included 70% alcohol and that's what they were using and were being told it was not good enough, she was told they should then get individual glucometers. No information was provided regarding an appropriate sanitizing solution.</p> <p>On 6/9/11 at 4:45 p.m., the DoN provided a list of residents who routinely had their blood sugar checked using a glucometer. There were 11 residents identified; she indicated one of the eleven checked her own blood sugar using her own glucometer. The ten [10] residents identified on the list were Sampled Resident #10, and Supplemental Sample Residents #5, #2, #40, #38, #39, #4, #36, #32, #21.</p> <p>3. During a tour of the general environment, on 6/10/11 at 10:00 a.m., the Holy Family Unit medication room was observed. There were open bottles of generic Pepto Bismol, and Milk of Magnesia. The bottles had not been dated when opened.</p> <p>During the same tour, the Jeanne Jugan Unit treatment room was observed. A cart with treatment supplies was observed. There was a bottle of 70% alcohol with an expiration date of 09-10. The same unit's</p>						

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	<p>medication room was observed. A bottle of Milk of Magnesia was observed opened. There was no date when the bottle had been opened. During interview at that time, the DoN indicated, the 70% alcohol was house stock.</p> <p>A census record, provided by the Director of Nurses on 6/6/11 at 9:45 a.m., indicated there were 27 residents residing on the Holy Family and Jeanne Jugan Units.</p> <p>4. The policy and procedure for Medication Storage in the Facility [no date] was provided by the Director of Nurses [DoN] on 6/13/11 at 12:10 p.m. The policy indicated the following: "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier..." The procedure included, but was not limited to, outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists." "Medication storage conditions are monitored on a monthly basis and corrective action taken if problems are identified."</p>						

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	<p>5. The Consultant Pharmacist Services Provider Requirements policy and procedure [no date] was provided by the Director of Nurses on 6/13/11 at 12:10 p.m. The policy and procedure included, but was not limited to, the following:</p> <p>"The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility. In collaboration with facility staff, the consultant pharmacist helps to identify, communicate, address, and resolve concerns and issues related to the provision of pharmaceutical services. This includes, but is not limited to:</p> <ul style="list-style-type: none"> -Assisting in the identification and evaluation of medication-related issues, including the prevention and reporting of medication errors and the provision and monitoring the use of medication-related devices. -Assisting in the assessment and improvement in nursing staff medication administration, including infusion therapy and use of medication delivery and testing devices, through medication pass observation and through medication record reviews." <p>"Specific activities....includes, but is not limited to:</p> <p>...checking the medication storage areas at least monthly, and the medication carts at least quarterly, for proper storage and</p>						

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	labeling of medications, cleanliness, and removal of expired medications." 3.1-25(e)(1) 3.1-25(o)						

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F0441 SS=E	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure residents were safe from risk of nosocomial infection, for 2 of 2 supplemental sample residents [Resident</p>			F0441	<p>The facility adopted a new glucometer disinfectant policy. During the survey process each resident who had orders for accuchecks were given their own individual glucometer. Nurses and</p>		07/14/2011

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	<p>#5, Resident #36] who were observed to have their blood sugar checked per glucometer, in the supplemental sample of 29, in that glucometers were not sanitized between residents. This deficient practice had the potential to affect 10 residents who were documented to have glucometer checks ordered per the attending physicians, within a facility census of 42. [sampled resident #10, supplemental sample Residents #5, #2, #40, #38, #39, #4, #36, #32, #21]</p> <p>B. Based on observation, interview and record review, the facility failed to ensure gloves were worn when needed, to ensure gloves were changed and hands washed between soiled and clean tasks, to ensure hands were washed for a sufficient length of time, during care observations by facility staff for 5 of 5 sampled residents, in the sample of 11 (Residents #41, #29, #12, #5, #30), and for 1 of 1 supplemental sample resident, in the supplemental sample of 29 (Resident #5).</p> <p>Findings include:</p> <p>A1. The medication pass observation began on 06/08/11 at 11:35 A.M.</p> <p>QMA #1 was observed to retrieve a glucometer from the medication cart,</p>				<p>QMAs were in-serviced on June 23, June 24, June 27, and will be in-serviced on July 1, 2011, addressing glucose testing and glucometer disinfecting. New hires will be in-serviced during orientation process on glucometer testing and glucometer disinfecting. Ongoing in-services will occur bi-annually. Nurses and QMAs will be monitored twice weekly regarding glucometer sanitation. Consulting pharmacist has reviewed the policy on glucometer testing and disinfecting and will monitor staff monthly on performance of disinfecting glucometer. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 07/08/11</p> <p>Mandatory in-services were held on June 14 and June 20, 2011 for all nursing employees addressing policies and procedures for correct handwashing techniques. Nursing staff will be monitored for correct handwashing techniques five times weekly for one month. Monitoring will continue twice weekly for randomly selected employees. All new nursing employees will be in-serviced on correct handwashing techniques during orientation. Ongoing in-services will occur bi-annually. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 06/30/11</p> <p>In-services were held on June 14, June 20, June 23, June 27, and will be held on July 1, 2011,</p>		

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	<p>obtain 3 alcohol pads, and 1 lancet strip and place these supplies on a blue tray. QMA #1 was then observed to take the supplies on the tray into the Room of Resident #5. QMA #1 was then observed to place tray on the bed of Resident #5, enter the bathroom of Resident #5 and perform handwashing for 10 seconds. QMA #1 was then observed to apply gloves and wipe the glucometer with an alcohol pad. QMA #1 was then observed to wipe the finger of Resident #5 with an alcohol prep pad and perform a fingerstick on Resident #5, without changing her gloves or performing hand hygiene. QMA #1 was then observed to touch the test strip to the finger of Resident #5 to obtain a drop of blood. QMA #1 was then observed to insert the test strip into an Optium EZ glucometer [a machine to check blood sugar].</p> <p>In an interview at that time, QMA #1 indicated, "Her Accucheck is 101."</p> <p>QMA #1 was then observed to remove her gloves and perform handwashing for 10 seconds. QMA #1 was then observed to wipe the glucometer with an alcohol pad and return it to the medication cart.</p> <p>In an interview with QMA #1, at that time, she indicated, "There are two Accuchecks on this floor, [name of</p>				<p>regarding correct glove usage and procedures. Proper glove usage will be monitored five times a week for one month. Monitoring will continue twice weekly for randomly selected employees. All new employees will be in-serviced on proper glove usage during orientation. Ongoing in-service will be held bi-annually. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 07/08/11 Mandatory in-services were held for all nursing employees on June 14 and June 20, 2011 addressing peri and incontinence care procedures. CNAs will be monitored providing peri-care five times a week for one month. Monitoring will continue twice weekly for randomly selected employees. All new employees will be in-serviced on peri-care during the orientation process and ongoing bi-annual in-servicing addressing peri-care will occur. The charge nurse, ADON and DON will monitor. Ongoing monitoring for one year. Completed 06/30/11 In-services will be held on July 7 and July 8, 2011 addressing medication administration and infection control. The facility's policy and procedure for medications will be in-serviced. Nurses and QMAs will be monitored daily for one month, and then twice weekly for correct medication administration and infection control. New hires will be</p>		

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	<p>Resident #5 and name of Resident # 40]. There is one glucometer for every unit, they [Resident #5 and Resident #40] share...The next Accucheck is at 5:30 P.M."</p> <p>During an interview, at that time, with QMA #1, when asked about the sanitizing protocol, she indicated, "We are supposed to clean it with alcohol each time we use it."</p> <p>In an interview with the DoN, on 06/08/11 at 5:00 P.M., she indicated, "We did not inservice on the Optium EZ [the glucometer that was used by QMA #1], it is just like the old one, we just don't have to reprogram like before."</p> <p>A2. On 6/8/11 at 11:35 a.m., LPN #2 was observed using a glucometer from the medication cart to check Resident #36's blood sugar. Upon completion of the procedure, she took an alcohol wipe and thoroughly wiped off the glucometer machine.</p> <p>On 6/8/11 at 12:03 p.m., LPN #2 was interviewed. She indicated she had no more blood glucoses to check. When queried about using alcohol swabs to disinfect the glucometer, she indicated that was what they were taught to use. At the same time, a policy and procedure was</p>				<p>in-serviced during orientation and ongoing in-service will occur bi-annually. Consultant pharmacist will perform medication administration review monthly for three months and then quarterly. The ADON and DON will monitor. Ongoing monitoring for one year. Completed date: 07/14/11</p>		

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	<p>observed posted on the medication room cabinet door. The policy indicated the facility was to disinfect the glucometers between residents with 70% alcohol swabs.</p> <p>At 12:05 p.m. on 6/8/11, the Director of Nurses [DoN] was interviewed. She indicated the facility had been cited on the previous annual survey for not sanitizing glucometers between residents. She indicated she had written the policy at that time and used their glucometer manufacturer's instructions to develop the policy.</p> <p>At 1:00 p.m. on 6/8/11, the DoN provided a copy of the cleaning instructions for the facility's model and brand of glucometer. The instructions were as follows: "Cleaning Your Monitor Store your monitor in its carrying case. If the surface of your monitor gets dirty, you may clean it. Use a damp cloth and mild soap. Healthcare professionals: Acceptable cleaning solutions include 10% Bleach, 70% Alcohol, or 10% Ammonia."</p> <p>On 6/9/11 at 9:30 a.m., the DoN was interviewed. At that time, she provided the manual for the facility's glucometer. It indicated it was appropriate to use in healthcare settings for more than one</p>						

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	<p>person. The DoN indicated she had called the manufacturer and they had indicated the facility should follow the instructions in the manual for cleaning. The DoN indicated checked the Centers for Disease Control [CDC] web site and was unable to find information. She then indicated she called the CDC and spoke to a representative. She was told to follow the manufacturer's recommendations. She indicated when she informed the CDC representative the instructions included 70% alcohol and that's what they were using and were being told it was not good enough, she was told they should then get individual glucometers. No information was provided regarding an appropriate sanitizing solution.</p> <p>On 6/9/11 at 4:45 p.m., the DoN provided a list of residents who routinely had their blood sugar checked using a glucometer. There were 11 residents identified; she indicated one of the eleven checked her own blood sugar using her own glucometer. The ten residents identified as having blood sugar checks done by the facility were the following: sampled resident #10, supplemental sample Residents #5, #2, #40, #38, #39, #4, #36, #32, #21.</p> <p>B1. On 6/7/11 at 8:40 a.m., CNA #3 was</p>						

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	<p>observed taking Resident #41 to the bathroom. When she finished with Resident #41, she exited the room. She then assisted Resident #9, in her wheelchair, to her room. She then went to Resident #29's room. CNA #3 and CNA #4 assisted Resident #29 to the bathroom. CNA #3 never washed her hands between the residents.</p> <p>CNA #3 and CNA #4 put on gloves. They assisted Resident #29 to the bathroom, using a sit to stand lift and placed her on the toilet. CNA #4 indicated the resident's pull-up type brief was wet. She placed the soiled brief in a plastic bag. The resident had a bowel movement while sitting on the toilet. CNA #4, wearing gloves, wiped the resident with toilet paper. With the same gloves, she pulled the clean brief and the resident's pants up. Then she took the gloves off, bagged up the soiled items and took them to the soiled utility room, where she washed her hands.</p> <p>B2. On 6/8/11 at 5:20 p.m., CNAs #1 and #2 were observed assisting Resident #12 to the bathroom. The resident was walked to the bathroom with a walker and two assist. A pull-up type of incontinence brief was removed. It was wet and soiled with a smear of feces.</p>						

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	<p>After giving the resident time on the toilet, CNA #2 washed the resident's perineal area by reaching through the legs from the front and, using wash cloths, washing the area from back to front.</p> <p>The policy and procedure for Perineal Care, dated 7/2005, indicated the purpose of the policy was "to clean the perineum, provide comfort, and to prevent infection." The procedure included, but was not limited to, the following: "wash female from top of vulva downward and rinse."</p> <p>During a random observation of the medication pass, on 06/08/11 at 12:00 P.M., RN #1 indicated she was preparing to administer medications and feeding through a gastrostomy tube [g-tube].</p> <p>RN #1 entered the room of Resident #12 and was then observed to enter the resident's bathroom and perform handwashing for 10 seconds. RN #1 was then observed to apply gloves. RN #1 was then observed to be unable to obtain a residual of feeding. RN #1 was then observed to remove gloves, perform handwashing for 8 seconds, and exit the room. RN #1 was then observed to re-enter the room, enter the bathroom and perform handwashing for 5 seconds. RN#1 was then observed to apply gloves</p>						

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	<p>and attempt to administer medications and a bolus feeding through the g-tube of Resident #12.</p> <p>Upon completion of the procedure, RN #1 was observed to remove her gloves and perform handwashing for 10 seconds. RN #1 was then observed to apply gloves and wipe the syringe with a paper towel. RN #1 was then observed to remove gloves and perform handwashing for 10 seconds. RN #1 was then observed to apply gloves and put supplies away. RN #1 was then observed to remove gloves and perform handwashing for 11 seconds.</p> <p>In an interview with RN #1, at that time, she indicated that hands were to be washed frequently.</p> <p>In an interview with the DoN, on 06/08/11 at 4:30 P.M., she indicated, "We just inserviced on ...handwashing."</p> <p>RN #2 was observed administering medications to Resident #12 through a gastrostomy tube on 6/8/11 at 5:50 p.m. She brought the medications to the room on a small plastic tray. She wore gloves. Prior to the administration of the medications, she removed the dressing around the g-tube entry site. It was soiled with light beige solution and a small</p>						

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	<p>amount of pinkish-red splotches. She then connected a syringe to the end of the g-tube to administer the medications. No glove changes or hand washing was done. She was unable to get any residual feeding from the tube and had to leave the room to get a stethoscope. She took off her gloves, but did not wash her hands.</p> <p>When she returned to the room, she put on another pair of gloves. She administered the medications and a can of feeding solution through the g-tube. With the same gloves, she used wound wash solution to wash around the g-tube site with a gauze pad. She then dried the area with a gauze pad and applied a clean dressing, using the same gloves. The syringe used to administer the medications and feeding had been placed on the plastic tray. She briefly rinsed the syringe and placed it back in a container at the bedside. She removed her gloves and carried the tray out of the room and to the medication room.</p> <p>In the medication room, RN #2 was observed to obtain hand soap from the wall dispenser and wash the plastic tray at the same time she was washing her hands.</p> <p>B3. During the medication pass, on 6/8/11 at 1:03 p.m., RN #1 was observed administering medications to Resident</p>						

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	<p>#30. She dropped a pill onto the resident's blanket, scooped up the pill with a spoon and placed it in the resident's mouth.</p> <p>B4. LPN #2 was observed, on 06/08/11 at 11:50 A.M., to administer insulin to Resident #5. LPN #2 was observed to administer the insulin without applying gloves. In an interview at that time LPN #2 indicated, "I forgot to wear my gloves." LPN #2 was then observed to perform handwashing and while drying her hands, LPN #2 was observed to drop a paper towel on the floor, retrieve it, and use it to continue drying her hands. LPN #2 was not observed to sanitize her hands after using the dropped paper towel to dry her hands.</p> <p>A policy and procedure for Handwashing, dated 05/2006, provided by the DoN on 06/08/11 at 5:15 P.M., indicated, "Policy All staff providing direct patient care or having any physical contact with resident or their equipment shall wash their hands frequently. This will include, but is not limited to:</p> <ol style="list-style-type: none"> 2. Between contact with different Resident 3. Before and after any physical contact with Resident equipment or personal article... Before and after any procedure with Resident...7. After the removal of gloves... Procedure...2. lather hands and rub vigorously for ten to fifteen (10-15) 						

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	seconds." The Centers for Disease Control and Prevention document, "Handwashing: Clean Hands Save Lives," provided by the DoN on 06/13/11 at 2:25 P.M., indicated, "What is the right way to wash your hands? Wet your hands...rub your hands together to make a lather and scrub them well;...Continue rubbing your hands for at least 20 seconds..." 3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(l)						

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F0520 SS=F	<p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to ensure the quality assessment and assurance committee identified quality deficiencies, developed and implemented plans of actions to correct deficiencies, and had a plan in place for on-going monitoring of corrective action. This deficient practice had the potential to affect all 42 residents residing in the facility.</p> <p>Finding include:</p>			F0520	<p>An in-service was held on June 27 and June 29, 2011 for members of the QA committee reviewing the facility's QA policy and procedures. The ADON, who is the QA Coordinator, was in-serviced on June 27, 2011 on the responsibilities of the QA Coordinator. The Medical Director reviewed the QA policy and procedures on June 29, 2011. The QA Committee will continue to meet quarterly to identify qualities and deficiencies and implement appropriate plans of corrective action. When indicated, the QA committee will develop an</p>		07/05/2011

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	<p>On 6/10/11 at 11:15 a.m., the Director of Nurses [DoN] was interviewed regarding the facility's Quality Assessment and Assurance Program [QAA]. She indicated the facility did have a program and the Assistant Director of Nursing conducted the meetings. The current Assistant Director of Nursing had only been employed for a few weeks, so she had not been involved in QAA yet. The former Assistant Director of Nurse had been gone for 3-4 weeks. The committee consisted of the Director of Nurses, the Assistant Director of Nurses, Social Services, Activities, the President of the facility, the Medical Director, Housekeeping Supervisor, Maintenance Director, Pharmacist, Human Resources Director, Dietary Manager. She indicated they met quarterly.</p> <p>The DoN indicated they had certain criteria they reviewed, for example infection control, safety, pharmacy reports, inservices. When queried how the committee determined issues for the Quality Assessment and Assurance Committee [QAA] to follow, she indicated, "We really don't have anything come up, really no problems." She further indicated they reviewed infections, incidents/accidents, employee safety, as routine items. When queried about contracted services being part of the QAA</p>				<p>ongoing monitoring system where as the medical staff and ancillary personnel will be able to identify and improve problem areas impacting directly or indirectly on resident care. The next QA meeting will be in July 2011. The QA program will be reviewed quarterly by the QA Committee to ensure that the program is comprehensive and effective in improving resident care. The QA plan will be approved by the medical staff, the administrator, and governing body. The administrator and the DON will monitor. Ongoing monitoring for one year.</p>		

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	<p>review, such as therapy, she indicated it was not on their agenda.</p> <p>The DoN indicated issues were documented in the minutes and discussed at the meetings. She indicated the same issues were followed each meeting. The DoN was unable to describe the process from beginning to end using an example of an issue. When queried about the frequent falls, she indicated they always looked at what shift and what time people were falling, to try to find out why they were falling. She indicated other than evaluating the trends in falls, no corrective action had been initiated.</p> <p>The Quality Assurance-Improvement Program policy and procedure, dated 5/2006, was provided by the DoN on 6/13/11 at 12:10 p.m. The Purpose of the policy included the following:</p> <p>"1. To identify qualities, deficiencies and implementing appropriate plans of corrective action.</p> <p>2. To develop a comprehensive QA program that will apply to all departments, services and practitioners in the home in an effort to maintain high quality patient care.</p> <p>3. To provide an integrated approach to the QA Program.</p> <p>4. To develop an on-going monitoring system whereby the Governing Body</p>						

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	<p>Administration, Medical Staff and Ancillary Personnel will be able to identify and improve problem areas impacting directly or indirectly on patient care."</p> <p>Responsibilities included, but were not limited to, the following: Department Heads: "To evaluate the quality of care they provide and to establish criteria to monitor their services." "The responsibility for meeting all QA activities shall be retained by the department heads and reports shall be submitted to the QA Coordinator upon request." QA Committee: "To provide the mechanism for the organized, objective review and evaluation of Resident care." "To coordinate a comprehensive QA Program involving medical, nursing, and other ancillary support services." "To monitor appropriateness of topics and validity of criteria." "To ensure that problems identified through QA activities are addressed and solved in a timely manner." QA Coordinator: "Keep up-to-date on quality assurance. Review changes with the Committee and making recommendations geared toward meeting regulations and standards."</p>						

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	<p>"Develop and initiate effective procedures to carry out quality assessment activities as instructed by the Committee."</p> <p>"Develop and institute methods to provide statistical profiles and other data to the Committee to assist in evaluation of quality of care."</p> <p>"Coordinate development of evaluation studies, solicit topics, help design screening criteria and facilitate interdepartmental participation."</p> <p>"To monitor the implementation of recommendations for corrective action."</p> <p>Regarding Problem Identification: "A problem shall be defined as a deviation from an expected occurrence that may not be justified as appropriate." "All studies will be problem-oriented and deal with suspected problems or focus on areas where the potential for problems is high." "The problem that has the most adverse affect on Resident care will have priority."</p> <p>Regarding Problem Assessment: "Written criteria will be used to assess problems and to measure achievable goals. Those criteria may be related to process, to outcome, to standards of practice within professional organizations, or standards developed within the home." "It is recommended that studies be traditional medical audits."</p>						

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